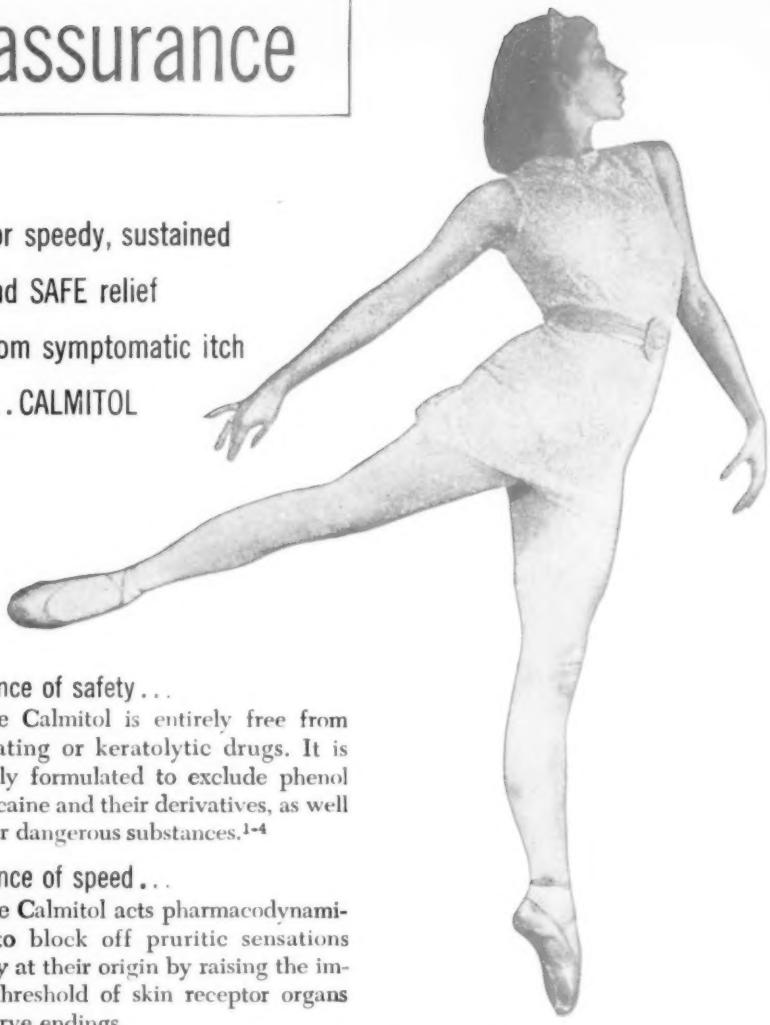

R.N.
EPT. 1949

assurance



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1. Underwood, G. B., and Gaul, L. E.: J.A.M.A. 138:570, 1948. 2. Underwood, G. B.; Gaul, L. E.; Collins, E., and Mosby, M.: J.A.M.A. 130:249, 1946. 3. Andrews, G. C.: Diseases of the Skin, Philadelphia, W. B. Saunders Co., 1946. 4. Gaul, L. E. J.A.M.A. 127:439, 1945.

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vol. 12, no. 12

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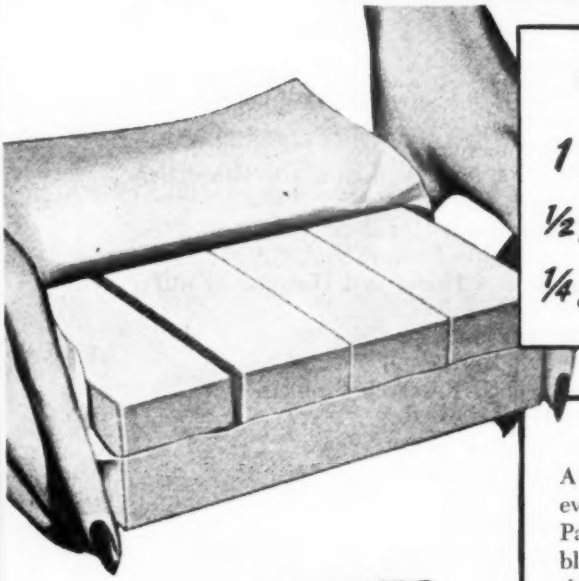

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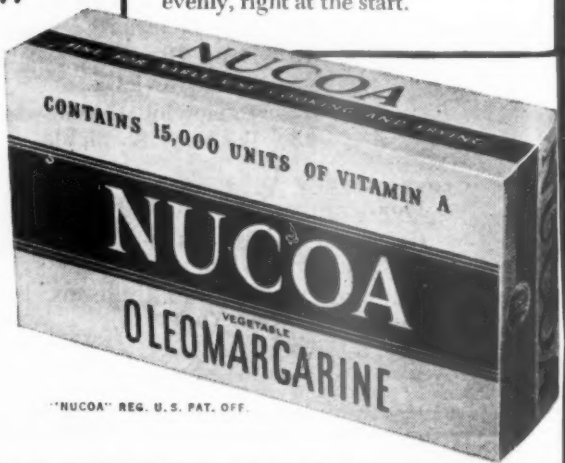

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DEBITS & CREDITS

Masters of Our Fate?

Dear Editor:

I enjoyed "Compromise or Conversion?" and Candid Comments—"On the Spirit of Nursing" [R.N., Nov.]. I repeatedly tell my less interested colleagues that if they read your editorials and Miss Janet Geister's articles, they will be well-informed on present day events.

I happen to feel very deeply about any nursing organization accepting lay membership or having lay people tell the nursing profession what to do. Dr. J. C. Meaken stated, in his address to the 1948 graduating class at Mary Fletcher Hospital, Burlington, Vermont, that a profession is in no sense of the word a profession if it leaves the shaping of its destiny to others. We have qualified nurses within our profession who have both the knowledge and ability to solve the profession's problems. Let's use them.

M. Blanche Adams, R.N.
MIAMI, FLA.

Inactive?

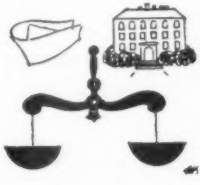
Dear Editor:

Remember us—the R.N.'s who married and retired from nursing? Well, I for one, found out that you can't retire—you never stop being a nurse. Some of us are resolving our conflicts between home and duty by keeping in the swim on a sort of good neighbor basis. We don't work regularly or work for pay, but we go out among our friends and neighbors teaching Home Nursing and doing Visiting Nursing. We carry our youngsters along with us and put on a uniform and cap while we work.

We offer to give penicillin and streptomycin hypodermics and other treatments which, otherwise, would mean a stay in the hospital for some. The doctors soon catch on to the idea and leave written orders to help. We teach someone in the household to give baths and take temperatures. Usually one or two visits suffice, with a dozen or so telephone check-ups on the way things are going for the at-home patient.

For hospitals badly in need of nurses, many of us can manage a few hours daily to help over the rough periods. We don't make much money, but we renew contacts with our own group which is always worth something to a nurse.

For those of us who can't give full time to hospital work, I'd like to suggest a two-week refresher course to be given periodically by training



schools. They could conduct morning and evening courses demonstrating new techniques, medications and policies. In this way those of us who are only part-time nurses could acquire the know-how to do a better job. We just can't stop nursing while we're needed. A friend of mine recently said, "I get so hopping mad when people say to me, 'Oh, were you a nurse?' I glare at them and say 'I *am* a nurse!' "

MRS. FAUNTELLA T. JENSEN, R.N.
OGDEN, UTAH

How About This?

Dear Editor:

I think your plan to publish monthly drug articles is a fine idea and a way to refresh our memory in pharmacology through the *Drug Digest* department. I find it very easy to forget dosages, etc. of the more familiar medications and with the many new drugs on the market, I am lost. This is especially true when you are away from medicines.

May I suggest that these pages be perforated so they can be removed and kept in a note book for our own use? I am sure other nurses will enjoy this refresher course as I do.

HELEN J. CARROLL, R.N.
NORFOLK, VA.

*

Dear Editor:

I enjoy **R.N.** and always pass it on to other nurses.

I would like to suggest that you publish a booklet of the drug articles and *Drug Digest*. I am sure several nurses would like to buy a copy for

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reference, as many of the new drugs or synthetics are certainly confusing.

LAURA C. FOLLIN, R.N.
SAN DIEGO, CALIF.

[*The* Drug Digest *format is purposely designed to encourage clipping, but if some readers prefer to keep their issues intact, reprints of the department and accompanying article are available at a small fee if sufficient requests are made. We will, however, take your welcome suggestions under consideration.*—THE EDITORS]

Definition Wanted

Dear Editor:

Over a period of years during my career as an R.N., I've heard the term "good nurse." I would like to know just what makes a "good nurse."

When I entered training, back in the dark ages of nursing, our class was instructed that we must learn to sacrifice in order to be good nurses. I've worked with some nurses who were considered good nurses. They worked overtime in order to give some patients extra attention, or just in order to get work out. (Secretly, I thought some of them did this because they had an uninteresting private life.) Others were considered good nurses because they made no demands for themselves (although they should have).

I often wonder just how much of this sort of thing should be expected in the name of good nursing. Some doctors seem to have a peculiar idea of what a good nurse is; she seems

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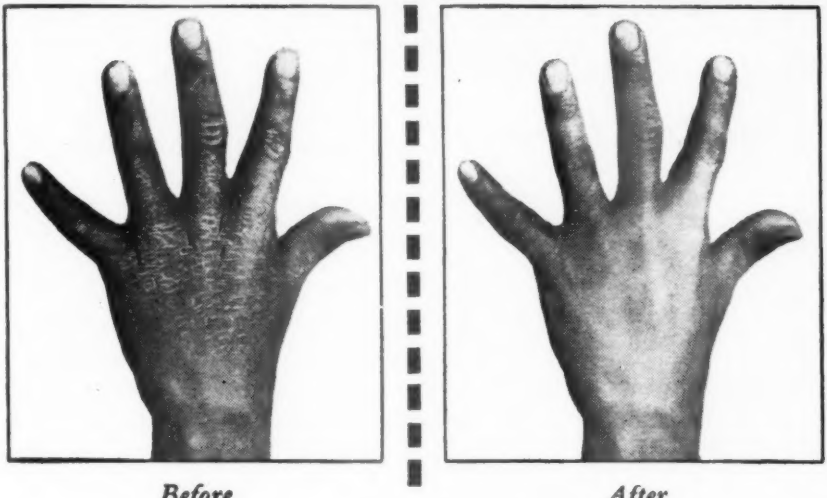

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to be one who doesn't cross them or keep them waiting.

Perhaps some of your readers could tell me just what is the criterion for judging a "good nurse."

R.N., DAYTON, OHIO

Professional Academy?

Dear Editor:

I have read and listened to the pros and cons of socialized medicine, and to my mind the greatest argument against it is the well known shortage of medical personnel. We appear not to have enough doctors, nurses or technicians for our present demand.

The U.S. Government does a very efficient job of training excellent soldiers and sailors at West Point and Annapolis. Now, with the demand for medical personnel in Government hospitals on the increase, why could not similar schools be set up for doctors, nurses and technicians?

With more nurses available, perhaps the public health nursing programs could be increased to help more persons.

R.N., ERIE, PA.

Dose Insufficient

Dear Editor:

One of your recent articles was on bibliotherapy [R.N., March]. Please continue to send me your magazine—it is an excellent bibliotherapy measure for me. My only complaint is its infrequency—only a monthly—and its small size.

May I suggest—if it hasn't been

done already—a series on "Socialization of Medicine"—proposals suggested by the Federal Government and also some of the myriad non-governmental plans. The air all about us is loud with noises pro and con made by physicians, but they are not the only ones involved in this matter—regardless of what form future medical economics takes. There are we nurses, and technicians of all sorts, as well as the all important person, the patient. Some of the public forums mention only one profession involved—the doctor.

I am sure I could use much more information on this subject, as to how it would affect us as patients and as professional workers in the future.

RUTH SCHANK, R.N.
BROOKLYN, N.Y.

[*We thank you for those kind words. References to proposed compulsory and voluntary prepayment health insurance plans will be found in past issues of* R.N. *in the following issues: Dec. p. 28, Jan. p. 20, Feb. p. 32, April pp. 8, 10, 12, May pp. 12, 14, 16.*—THE EDITORS]

Leave Us Be!

Dear Editor:

I have enjoyed your feature, "Phot-O-pinion" very much. I cannot say, however, that I was totally in favor of the one about men nurses [R.N., March]. Because they are greatly in the minority is not, in my opinion, any reason for discussion. I have written about men nurses and have had some work published, but my

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present reaction is somewhat like that of the Englishman, who, on a visit to the U.S., was struck by the many meetings attended by his host. Said he, "I think the U.S. is a wonderful country, but I sincerely believe there should be one meeting to end all further meetings."

Because my sex is in the minority in nursing does not in any way prevent me from being heard or, more important, from listening when others speak. The eternal question "To be or not to be," as it relates to men nurses only prolongs an unnecessary controversy. Some one has said that the Battle of the Sexes will never be won anyway—there is too much fraternization. When we admit that there is no cause for discussion and get busy to solve the far more serious problems that face the profession as a whole, we will have gone far in one single step.

WESTON A. RUTH, R.N.
NAPANOCH, N.Y.

[*We don't quite agree with Mr. Ruth. Men nurses still have a long way to go and a big public relations job to do before they should be satisfied.*—THE EDITORS]

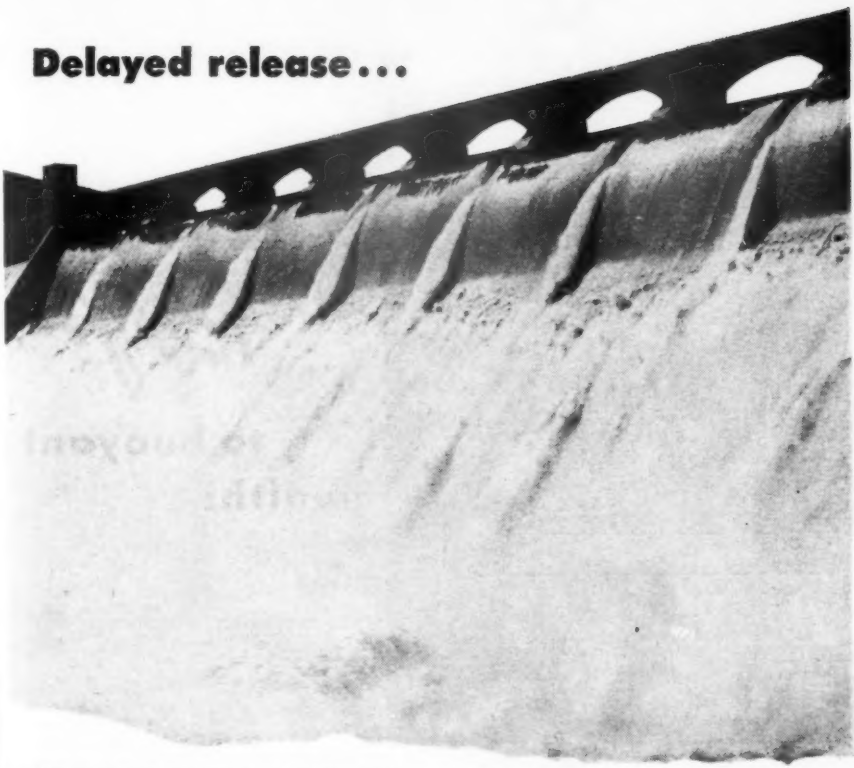
Pertinent Point

Dear Editor:

Can someone please tell me how we can expect young women to be attracted to the nursing profession with the threat of Socialized Medicine hanging over us?

MRS. VIOLET WELLS, R.N.
FREEPORT, ILL.

Delayed release...



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references

1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947. 2. Manchester, T. C.: Food Research, 7:394, 1942. 3. McLester, J. S.: Nutrition and Diet, Saunders, 4th ed., 1944. 4. Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944. 5. Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1946.

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SCIENCE SHORTS

A daily quart of raw cabbage juice, containing an unidentifiable anti-peptic ulcer factor, proved unusually effective in curing duodenal and gastric ulcers in a study group of 13 patients, according to Dr. Garnett Cheney of Stanford University Medical School in *California Medicine*. These ulcers had an average healing time of nine days as compared with that of 37 days for patients receiving routine treatment.

*

A bone tumor registry in connection with the University of Oregon Medical School is being planned to facilitate prompt diagnoses of malignant bone growths, and as an aid in consultation, teaching and research.

*

Ulcerative colitis may yield to Thalamyd, a new sulfa compound developed by Drs. Harry Seneca and Edward Henderson of the clinical research division of Schering Corp. In the group of 70 patients treated with the new compound, some were under observation nearly a year; failure resulted in only 10 per cent of the cases, and none showed harmful side effects. Thalamyd appears to suppress growth of bacteria, thus removing possibilities of secondary infection and enhancing healing.

*

Most cases of breast cancer occur in women after the ages of 40 or 45. Breasts that have been the site of other diseases or have never lactated are most susceptible; there is no evidence that heredity or traumatic injury results in cancer.

*

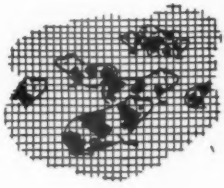
A new vitamin called B-14, isolated in crystalline form from human urine, checks the growth of rabbit cancer cells and increases red blood cell production in test tube experiments, according to Earl R. Norris and John J. Majnarich, biochemists of the University of Washington at Seattle. Whether this discovery will have any bearing on human cancer depends on more investigation.

*

The Metropolitan Life Insurance Company reports that appendicitis which caused 11.1 deaths per 100,000 policyholders in 1937-1938, was responsible for 2.7 deaths in 1947-1948—a drop of 76 per cent.

*

Three Puerto Rican physicians, reporting the favorable results of their planned study in the JAMA, concluded that penicillin in large amounts is a useful assistant to tetanus anti-toxin in the treatment of patients with established diagnosis



of tetanus. This conclusion is based on an experiment with 59 patients, 47 of whom survived.

*

A recent study of 100 school children by Dr. Seymour A. Watsky, of New York, revealed that more than 21 per cent of decayed teeth could not be detected without the help of x-ray.

*

Three New York physicians, writing in the *American Journal of Medical Sciences,* suggest the use of colloidal iron hydroxide in the treatment of hypochromic anemia. They found the latter drug produced less severe gastro-intestinal complaints than ferrous sulfate, and the daily iron utilization was equivalent to ferrous sulfate and achieved with a smaller dose.

*

The Rondo Carton, a new paperboard container, introduced by Winthrop-Stearns, Inc., protects glass ampuls from breaking during transit, and facilitates their storage in hospitals and doctors' offices.

*

The disposal of waste which has become contaminated with radioactive isotopes was discussed by Dr. Dewitt Stetten, Jr., in the *Bulletin of the New York Academy of Medicine.* The usual methods of waste disposal such as incineration, burial, or discharge into the waterways and ocean are sufficient at the present time, but would not appear to be adequate as a long term solution of the problem, as radioactive isotopes have a relatively long life. The clean-

A PARALLEL TO THE Rh FACTOR

IN 1938 a substance was discovered in the red blood cells of rhesus monkeys that was found to be also present in 87 per cent of the population of the United States. The other 13 per cent do not have it. It is inherited just like the color of eyes and hair.

Because this blood factor was first observed in rhesus monkeys, it was named the "Rh factor". Those who have it are Rh positive; those without it are Rh negative. Those who do not have it may be sensitive (allergic) to it; that is why when an Rh positive man marries an Rh negative woman, there may be trouble ahead for about 4 out of 100 cases in the course of childbearing.

Fortunately, when medicine knows the cause, it usually soon finds the remedy. Today most infants born to parents whose blood differs in relation to the Rh factor, are saved. The rhesus monkey has pointed the way toward saving life and promoting medical progress.

At about the same time that the Rh factor was discovered, the rhesus monkey demonstrated its usefulness again when it was found that the physiological action of phenolphthalein can be reliably determined by using the rhesus monkey as test subject. The method was adopted for Ex-Lax, making it the only laxative with its efficiency safeguarded by this method of standardization. Biological assay on rhesus monkeys is, of course, in no way related to the Rh factor, except that the rhesus (Rh) monkey was the test subject by means of which both of these discoveries were made.

With the proved therapeutic effectiveness of Ex-Lax go its wide margin of safety and unusual palatability. When pleasing taste counts, the chocolated base of Ex-Lax makes it readily acceptable, especially during pregnancy and in administration to children. In proportionate doses, Ex-Lax is equally suitable for use by adults and children.

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The extensive use of Ex-Lax makes its economical price possible. This Chocolated Laxative is available in boxes of 6 tablets — 10 cents, and 18 tablets—25 cents. A professional trial supply gladly sent to nurses. Ex-Lax, Inc., Brooklyn 17, N. Y.

ing of any surface which has been in contact with these materials is extremely difficult, as they will withstand almost astronomical dilution before all traces of them vanish. It has been stated that whole laboratories may already be contaminated to such an extent as to render them unfit for further studies involving the measurement of radioactivity and also present a hazard to workers.

*

To avoid television eyestrain the JAMA recommends the use of a large daylight screen, placed perpendicularly at a distance of 10 feet or more from the spectator.

*

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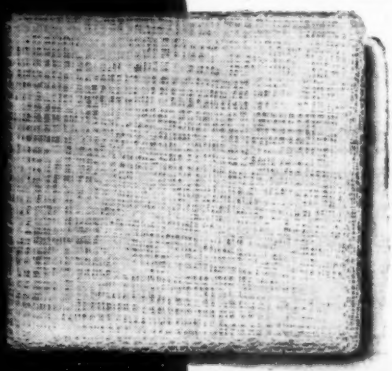

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R.N. Speaks: ON GOIN' TO M

GOING TO MEETINGS has become an integral part of the social and economic scheme of our lives. We constantly find ourselves meeting in groups (family, church, civic and professional). However, the only way these groups meeting together can make progress is for all to learn from each other, and the one way of learning is to compare notes, notions and viewpoints.

There is much to criticize in many of our nurses' professional meetings. To paraphrase Robert Burns: "Oh wad some Power the giftie gie us to see our meetings as ithers see us." Nurses believe they are not getting their money's worth; therefore, they don't attend professional meetings. We exhort, send postcards, offer coffee and sandwiches to increase attendance. We scold, devise various ways of trying to entice them, but the ratio of attendance to membership is discouragingly low. As a matter of fact, we do everything but the most important thing—make meetings so valuable and interesting that nurses can't afford to miss them.

How to do this? The only way is to understand *why* we have meetings and *how* to plan, organize and gear them to modern needs rather than following patterns useful 25 years ago, but definitely outmoded today.

Decades ago, when nursing literature was scant, it was necessary to use every opportunity to increase our knowledge of technical subjects and better techniques in nursing. Today, with more books, more local and national publications, more health department literature available, this is not necessary. Although it is still important to increase this knowledge, we should not be wholly preoccupied with it at our meetings.

There are more than technical subjects of interest to nurses in this era. Today we have four major interests. Formerly, the average nurse confined her interest to the sick room and the institution. Now she must relate herself to the patient, to her profession, to the profession's tool for action—the organization, and finally, to her place in the community. Her horizon has broadened infinitely.

Decades ago, when organization was new, all work was done by a few committees. There were no paid executives except one or two in

TO MEETIN'

the national scene; neither were there as many committees as we have now. Nursing organizations were forming; consequently, committee reports *had* to dominate meetings. Then there was need and time to have these reports carefully presented. Today, we have many more committees, as problems and issues increase, yet we still follow the old pattern of having every committee report read, discussed and formally accepted. Despite the fact that three-quarters of the reports aren't heard beyond the third row, and nine-tenths aren't remembered, they do remain important in our affairs, but we haven't as yet devised new ways of bringing them to the membership's attention and making them more useful.

Decades ago, when literature was scant and the issues before us were less overwhelming and numerous, almost any subject selected for meetings was apropos. However, in the present day, with many more issues before us, many other problems demanding our interest and attention, it is vitally essential to plan our programs well in advance, not for a single meeting, but for a series of meetings, projected around a central theme or issue.

Decades ago, it was the style to place the burden of thinking and of presentation upon the rostrum. The lecturer and his or her lectures were dominant. Today, modern education (both formal and informal) depends more and more on group participation and less on preachments from the platform. We still need lecturers, but in proper perspective. We also need discussion groups, group participation and more swapping of our own experiences, ideas and convictions.

The result of our lag is that too many of our meetings follow the old pattern without the old vitality. Our programs for the year are too often shapeless. The program chairman writes, telephones, interviews until some big-name speaker consents to come. The speaker is not chosen to present some aspect of the central theme which the district or state is studying, but rather the program is set around a topic of the speaker's choosing. The result often is a hodge-podge of subjects over a period of time that could be comic if it weren't so tragic.

Why do professional groups have meetings: To hear book reviews, a lecture on "The Life and Habits of the [*Continued on page* 78]

CANDID COMMENTS—WH

THE MAJOR NURSING problems in our hospitals cannot be solved until nurses have a greater voice in planning and policy making. The institutions recognizing this fact will find the quickest and surest answers; those that do not will muddle along with increasing troubles. Things can be done *for* nurses that will help, but only when they are done *with* nurses will we get the lasting and mutually profitable reform that will restore adequate care for patients.

Bringing nurses into the councils is not a concession or a gift—it is rank necessity. Personnel is more important than equipment—a truth that has been tragically long in dawning—and nurses are a major part of the personnel. More and more responsibilities fall on them as medical science continues its great strides, and nurses must be more than automatons wearing blinders against all but obedience to orders. They have to be thinking, disciplined persons with a strong sense of responsibility to community and hospital as well as to patient.

Today's nursing calls for teamwork of the highest order, not only among those actually serving at the bedside, but also among all who are connected with hospital organization and administration. The whole basis of modern medical care is teamwork, and no part of the team can function fully if it is subordinate.

Today both the planning and construction of hospitals call for the active participation of the people who walk and work in the miles of corridors. They know the price of the false economy that expends personnel rather than equipment. They know, for example, that in the end it is cheaper to pipe water into rooms and wards than to have nurses do "five turns to the mile" fetching drinks. Early ambulation and changes in diagnostic and treatment methods involve changes in setup and work planning that require the ideas and experiences of more than the architect and building committee.

Efficiency, economy, the patient's safety and comfort demand that the nurse abandon her position of subordination for one of partnership. We need in every hospital a Nurses' Board, operating closely with the board of directors and management, just as does the Medical Board. The director of nurses needs to be given authorities commensurate with her responsibilities. Staff nurses should be given the privilege as well as the responsibility for forming the policies that govern adequate patient care.

The whole scene has changed rad-

WHY NOT NURSES' BOARDS FOR HOSPITALS?

by Janet M. Geister, R.N.

ically since the days when we were told in a text book on ethics that "an important duty for the nurse at this stage is meekly to accept as right and necessary much that she cannot understand." Science is so much a part of nursing today and nursing has broadened so greatly in its services, that the nurse's first duty is to *know* and *understand*. Among other things she must understand her part in the whole plan for patient care, for nursing is so essential in modern treatment that the smallest failure on her part can mean disaster to the whole plan. The meekness that was once demanded of us denies the individual her essential humanity; it limits her usefulness; it robs the institution and community of her full powers.

We worry and puzzle over the careless work we see in some places. We mourn the absence of the old fashioned qualities in others. We work without pause to remedy bad personnel practices, weaknesses in nursing education, inadequate patient care, shortages. Our gains in these areas must be consolidated into the larger objective of bringing nursing to its greatest usefulness through proper prestige and authority. Indeed, most of our ills are the natural by-products of the stress on meekness, of our own failure to place more value on our own efforts.

On a survey one time I walked with a nursing executive through the living room of a nurses' home. Upon our entrance a group of students singing gaily at the piano, froze to rigid attention while we traversed the long room. Their silence seemed to me to be a terrible reproach on our misconception of traditions. Relieved, as we gained the outer door, I asked, "Weren't those girls off duty?" The tart reply was "Yes, they were off duty. But they have to be kept in their place at all hours and at all times."

The effects of this attitude are reflected in our troubles today. We failed to develop the whole nurse; instead we only developed the part that was immediately useful and subject to command. As nursing grew in stature and essentiality, and as it became increasingly necessary for nurses to walk shoulder to shoulder with their teammates in the health enterprise, our repressions continued. We can no longer afford repressions—if we ever could. We need the full powers of the whole nurse. If she is capable of acquiring the skills and knowledges needed in the successful practice of nursing, she is capable too of the sound judgments needed in a partnership. Her ideas and wisdom are needed in the whole

scene, not only in the sick room. Industry and education are learning that cooperation in production entails participation in planning. Employers of nurses will learn this too.

Some years ago Minnie Goodnow published an article entitled "The Architect Needs a Nurse." She pleaded for nurse inclusion on the architect's committee. Miss Goodnow, born into a family of architects and experienced in hospital administration, *knew* the values of efficient utility rooms and labor saving devices. A few weeks later I called on a prominent hospital executive to find him laughing over the article. "Why, the idea of a nurse telling the architect how to plan!" His whole attitude was "*Why* ask the nurses? They only work here."

Today he, and too many like him, still ignore the help available in the counsel of nurses. They believe they are doing all that can be done to meet shortages, by bringing in scores of helpers—still without consultation with the nursing staff. It is true that professional nurses can and should be relieved of non-nursing tasks, but you cannot build team play without consultation with the players. Every successful baseball manager knows that, and every one managing personnel ought to know it.

The nurse whose opinion is asked, who helps shape policies and plans, is bound to be a more responsible person. "This is *our* plan, *our* hospital. These are *our* patients." That isn't theory, it's horse sense. Just bringing in more sets of hands and feet without working out a central plan with the nurses whose cooperation is necessary to success, seems to me to be utter folly.

To return to the architect, many of us remember what monstrous women-killers our home kitchens were before women insisted on having a hand in the planning. Today we have the miracle of the modern kitchen because the people *who use the kitchens* share in the planning. Where nurses have a part in hospital planning the results are at once evident. Ten years ago Constance Appleton showed me a little gem of a hospital in Michigan that she had helped plan. From the nurse's station to the vegetable bins everything was planned for maximum usefulness with a minimum of effort. A flick of a switch and the nurse at her station could listen to the breathing of a patient in the remotest room.

Out on the West Coast a surgeon took home for study the plans for a mighty new hospital. Then he told the committee, "Don't put the utility rooms way off there. My wife is a nurse and she knows it won't work." It was fortunate that his wife was a nurse, but why weren't the plans referred for study to a Nurses' Board just as they were to the Medical Board? Probably because there was no Nurses' Board.

So far as we can learn there are no true Nurses' Boards anywhere, boards that operate freely and actively as do the Medical Boards, in representing the needs, aims and troubles of the group. We have Nursing Committees made up of members of boards of directors,

some of them quite useful, others apparently set up for decorative purposes. In some states operating under collective bargaining contracts, we have nurses' committees that could be the nucleus for a Nurses' Board. But there is nothing to indicate that the Nurses' Board as such now exists.

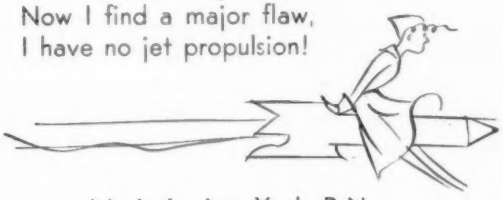
I believe that this lack of nurse participation in plans and policy making has a distinct bearing on the hospital's nursing troubles. The director of nursing, carrying the terrible responsibility of nursing care for patients 24 hours a day, needs direct access to the body that holds the purse strings and makes the laws —the board of directors. Too often today she reaches the board only through the person of the hospital administrator. He may be fully aware of what she is up against and wholly sympathetic with her objectives, yet still be unable to represent her case fully to the board. Again he may be out of sympathy with her, quite unable to understand the nature of her efforts and trials. What chance do her pleas have then with a board that gets them second hand?

Recently I came across an able nursing director ready to "give up hospital work for good and all." Her last trained supervisor had left. She and the other supervisors could no longer "take" the bad personnel practices. Henceforth every floor would be manned by student or "green" supervisors. "How can your board approve plans for 100 more beds if you can't hold enough nurses to care for your present patient census?" I asked. Her reply was typical of others: "I haven't the slightest idea how much the board knows or cares."

This director is not invited to board meetings. No board member goes to her with questions. Her reports and requests are transmitted to the board by the administrator. He likes the idea of student supervisors—it will save money, and anyway supervision is more or less window dressing. There is a Nursing Committee made up of board members but it meets only on call from the administrator, not the nursing director. He prepares the agenda. "If I resign this job," says she, "I'll probably resign nursing too, for the chances are [*Continued on page* 66]

ANATOMICAL HAS-BEEN

For my anatomy, so complete
I've never felt repulsion—
Now I find a major flaw,
I have no jet propulsion!



—Marjorie Ann York, R.N.

Can YOU run a Home and Hospital Ward?

● YOU ARE MARRIED and have two partially grown children. You have often thought of going back to nursing, but you don't quite know what to do with the dishes. Could you handle a house and a job at the same time? You can, as I've proved to the satisfaction of myself and my family.

I hadn't done any nursing since my marriage, 19 years before. During those years I had been busy and happy as a wife and the mother of two children. But in 1943, when my daughter was in her first year of college, my husband and I soon learned that we could use extra money. Furthermore, the nation was in the midst of war and nurses were needed. The logical solution was the simple one—I'd return to nursing.

After once making the decision I quickly went into action. I inquired

at St. John's Hospital in Tulsa, Oklahoma, and was hired as a nurse on the pediatrics ward. For a time, things were quite difficult and the only simple part of the process was buying new uniforms.

The first of my major discoveries was that taking care of one's own sick children at home is no substitute for nursing. I must admit that I had forgotten so much that for the first month I was probably both a poor nurse and a poor mother.

Gradually the old routines began to come back to me and eventually the household chores settled into an orderly schedule. No longer did I find myself trudging off to work leaving a wake of dirty dishes and incomplete menus behind me. My 13-year-old son stopped looking woebegone and my husband soon gained back the five pounds he had lost during the initial stages of the experiment.

The hours of my job were most fortunate. I went on duty at three o'clock in the afternoon and was off duty at 11 at night. This allowed me time in the morning to attend to the house and yet still gave me a good night's rest. Our home is within easy driving distance of the hospital and by taking the family car I could be at work in 15 minutes.

I got six and one-half hours of sleep at night and added to this by taking a midmorning nap. In this way it was no trick at all to get up at seven in the morning to get breakfast for my family. This was always a hearty meal of fruit, bacon, eggs, cereal and lots of toast and jam. In preparing breakfast I had to remember that I wouldn't be home to fix the family's evening meal.

Dishes for three are not difficult and they become less so when one learns the value of time. After morning dishes, there were the usual tasks of bedmaking and dusting. During the summer when my daughter was home from college, she did much of the daily housework after she came home from her summer job.

During most of my married life I have had a laundress and I did not give up this luxury with the resurrection of my "career." Our laundress came on Monday to wash and on Tuesday to iron. While she was working, I cleaned our six-room house thoroughly. I found it best to clean early in the week since weekends, when the family is at home, naturally bring disorder to a house.

For me the greatest pleasure of housekeeping has always been cooking. Before I returned to nursing I spent long, leisurely hours in the kitchen trying new cakes and fancy salads. With the advent of my job I had to forego this pleasure, but soon realized I was learning new things. I also learned the tremendous value of a pressure cooker in shortening time in the kitchen. I could cook a stew, for example, in relatively few minutes and leave it on the stove. My husband and son could then heat it and have a nutritious meal at night. Casserole dishes baked in the oven are also time-savers. On the other hand, [*Continued on page* 68]

by Bertha Shea, R.N.

POLIO NURSING in Mississippi

by Virginia Harrell

Ray Martin—The National Foundation for Infantile Paralysis

THE HEAD NURSE of the children's polio unit at Mercy Hospital, Vicksburg, Mississippi, 25-year-old Ethel Marjie Busby, has already mastered the fine art of handling people successfully. She keeps a sizeable staff of R.N.'s, paid aides and numerous volunteer help (Junior Auxiliary and Red Cross) working amiably side by side, which, considering the foibles of womanhood, is no small achievement. Watch her in action on a hot summer's day in the height of a high incident polio season such as this one and you'll also see that she's a nurse who understands children and knows her job.

Ethel Busby or "Buzz," as she is known to her patients and coworkers, received her nursing diploma in 1945 from Mercy Hospital. Soon after graduation she became floor supervisor and the following summer she and another nurse at her hospital were chosen by the National Foundation for Infantile Paralysis to take a two-week course in the modified Kenny treatment at Warm Springs, Georgia. In 1947 she was awarded a scholarship by the Foundation for a year's study in orthopedics at Boston University where she hopes, at some later date, to obtain her B.S. degree. In February, 1948 she returned to Mercy Hospital and its newly opened polio unit to apply what she had learned.

Polio patients from the entire state of Mississippi are brought to Vicksburg as it is the only town in the state which provides hospital space and professional services for this disease. Adult patients are treated at Vicksburg Hospital while children are cared for at Mercy Hospital which has a 40-bed polio ward. Normally this ward is only half-filled, but at the time of this writing, with the national figure increasing at an alarming rate, all beds are occupied. Miss

Busby's staff of three nurses and six aides has been doubled in order to take care of these extra cases but private duty nurses are still not available. The trouble seems to be that most nurses are afraid of the disease, particularly if they have children. When there is an acute case, the aides take over as much care as possible of the convalescents while the nurses concentrate on the critically ill child.

Miss Busby claims that she's never given much thought to the dangers of contagion—"You just can't be afraid while working with children." Mrs. Dorothy Kenworthy, one of the ward aides, in analyzing Miss Busby's success with children, says, "She teaches us to explain the whys and wherefores of everything we have to do to our patients without minimizing the seriousness of their illness. We treat them as adults and they respond with cooperation. For example, the hot packs sting and burn at first and in the acute stage it is necessary to apply them so often that many of the children think that we're overdoing it until they are shown how the packs relax their muscles and allow their arms or legs to straighten out naturally."

Steps in the general treatment of a new case admitted to Mercy's polio unit are:

1. Routine examination
2. Bath and shampoo on admission if condition allows
3. Vitamins — Vipenta drops 10 drops daily to young children, Unicap or Hepicebrin pill to older ones
4. Orange juice at 10 A. M. and 2 P. M. and water and other fruit juice during the day
5. Enteric coated sodium chloride gr. 7½ twice daily
6. Elimination check and accurate recording of intake and output
7. Hot packs every two hours and between times if patient complains of pain. Packs are left on 20-30 minutes.
8. Medication to relax unusually stiff muscles

The nurses at Mercy Hospital also stress the following points in the general treatment of the polio patient:

▶ Keep the patient in the most comfortable position during the acute painful stage, gradually stretching out the body in as near correct alignment as possible.

▶ Have the physical therapist stretch the involved muscles during the two daily tub baths in order to lessen the pain of stretching.

▶ When an arm or leg is involved, stretch it out after application of the hot packs while the muscle is relaxed in order to prevent contractures.

▶ In handling a child, be sure to do so securely and firmly; when a child senses that he is secure he will relax. Pick up the limb underneath the joint instead of underneath the muscle belly where the pain is centered.

▶ When a child starts to walk again he must learn, under guidance of the physical therapist, how to hold his muscles correctly in order to prevent bad walking habits. Once he is able to walk around the ward he must be watched at every step or he'll forget all that he's been taught.

▶ In nursing a patient with the bulbar type of polio, it is important to

explain symptoms to the patient so that he won't become frightened by the lack of muscle control in his throat. Postural drainage and gentle suction help remove mucus from the oropharynx. A tracheotomy may be necessary if there is severe spasm of the larynx. Patients should be closely observed for foamy saliva, tenacious sputum, nasal voice, hoarseness, inability to expectorate, strangulation and nausea. If the patient is able to take fluids, these should be fed to him slowly and in small amounts. If he can't swallow at all, he is fed intravenously, and after nausea subsides, by gavage. Tube feeding, where a child is concerned, can be rather dangerous as he is liable to regurgitate and aspirate the fluid. When swallowing reflexes have returned he is put on a very thin liquid diet including such fluids as broths and cola drinks. Nothing with milk in it should be given as the milk is apt to form mucus.

▶It may be necssary to place patients with respiratory paralysis in an iron lung to maintain breathing. Mercy Hospital has three iron lungs and shares a fourth with Vicksburg Hospital for such emergencies. Children are routinely administered oxygen if placed in the respirator.

But physical care, as vital as it is, is only one phase in nursing a polio victim back to health. In this disease, even more than in others, the emotional and mental health of the patient may make or break his recovery. Many times, nurses have seen how sheer determination has worked wonders. Miss Busby recalls a 14-year-old boy with muscle weakness who was determined that someday he would walk. When he left the hospital he was wearing a complete body brace. Just three months later he reported to the hospital for a check-up and proudly walked a few steps alone without a brace. This time he left the hospital wearing only a short leg brace.

How can nurses incite this determination and keep it alive in the listless, emaciated bodies of children to whom every movement is often an effort? Love, affection and attention, tempered with firmness, is the prescription of choice, says Miss Busby. That is why, on a busy day, one of the aides may be told, "Take the afternoon off and take Velma (the oldest respiratory case) downtown in her chair. A dose of sunshine and people will help her more than anything you could do for her here."

Firmness is also essential, for the children must know there is a time to play and a time to get things done. Sympathy is a tonic to be offered sparingly—for at the wrong time it can do considerable damage. Knowing this, the nurses have to watch the volunteer aides and parents, who are apt to smuggle in candy or entertain the children instead of devising ways for them to amuse themselves.

Getting the children to do everything possible for themselves taxes the hospital staff's ingenuity. Each case presents its own psychological problems and the solution may not be obvious. [*Continued on page* 60]

Polio ● A SPECIAL RESEARCH PROBLEM

by Frances Lewis, R.N.

FROM MAY TO OCTOBER, poliomyelitis pursues its unpredictable course through the country, playing havoc with human lives and limbs.

Although this disease appeared sporadically in the U.S. during the nineteenth century, it wasn't until 1916 that it assumed epidemic proportions. Since that time polio epidemics have become almost a tragic commonplace. Hardly a year goes by but what some state, some community comes under polio's dread shadow. Although the incidence of polio varies from year to year, the statistical record of the past six years is disheartening. Contrast the number of cases in 1942 – 4,033 – with 25,191 in 1946 and 27,894 in 1948.

What can be done to check this unwelcome summer invasion? Personal health measures may help to some degree; keeping children away from new groups of people; seeing that hands are washed frequently and kept away from the mouth; screening the house against flies; postponing tonsil and adenoid operations; forbidding swimming in polluted water; and avoiding over-exertion and sudden chilling. These measures must suffice, for to date no preventive or cure has been satisfactorily developed for poliomyelitis.

The natural immunity to the disease that is exhibited by the majority of persons may be due to repeated mild attacks unaccompanied by definite symptoms. The character of this immunity is now being explored by scientists who are trying to develop an efficacious vaccine. The usual methods of producing artificial immunity to disease by inoculation of living or dead organisms and serum containing antibodies, while successful in monkeys, have failed dismally thus far in protecting human beings. An emulsion of dead polio virus, given to children in 1935 proved ineffectual, while an attenuated live virus emulsion given in the same year accounted for 12 cases of polio and six deaths before its clinical use was forbidden by the USPHS. Last summer at the First International Poliomyelitis Conference, a report showed that Rhesus monkeys could be made immune by intramuscular injections of live virus or virus killed by formalin. Much more experimentation is indicated, however, before a vaccine of this type can be given safe, clinical trial.

Researchers in the preventive field of polio are hampered by several fac-

tors. First, the nature of the polio virus. Unlike bacteria and some of the larger viruses, the polio virus cannot be examined under the microscope. Like all viruses it is parasitic, that is, it cannot grow and multiply outside of living tissue. It is assumed that antibodies against the virus, carried in the blood, don't circulate within the nerve cells and therefore don't afford protection from virus invasion. However, it has been determined by some laboratory observers that an overproduction of antibodies as a consequence of vaccination will cause antibodies to spill over into the central nervous system and produce a state of immunity.

Another deterrent to research is the number of different polio viruses. There are at least three known immunologic types of polio virus and there may be more. Some of these types might respond to one vaccine and yet be untouched by another. As in influenza, an effective vaccine for polio may require a combination of immunological strains.

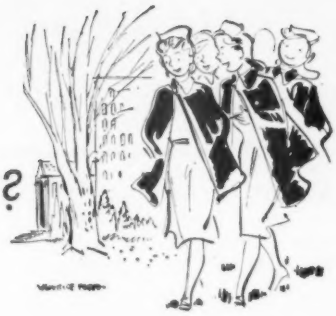
Despite difficulties and disappointments in the development of a vaccine, scientists have not given up hope of discovering some check for the polio virus. The National Foundation for Infantile Paralysis has given impetus to polio research by substantial financial aid. At present there are two Foundation-endowed projects especially concerned with antiviral drugs or specific chemicals for the polio virus.

Antiviral drugs differ from the chemotherapeutic agents used in bacterial diseases such as sulfonamides and antibiotics which interfere with the metabolic processes of the susceptible organisms. Since viruses are parasites usually possessing no enzyme system, the drug, to be effective, must change the physiology of the host cell which gives sustenance to the virus. Therefore, the ideal antiviral drug must not only penetrate the cell, but stop viral growth by changing the cell without damaging it. A large order, but there is reason to believe that there may be agents capable of doing it.

Scientists at the University of Minnesota have tested almost 400 compounds on an empirical basis, 67 of which show promise. Chief among these are benzidine dyes, especially trypan red which has saved about two-thirds of mice artificially infected with a murine virus or MM virus which, it must be emphasized, is not related to human polio. Another group of healthy mice were not affected by the injection of an emulsion of brains and cords of these "immune" mice. Fifteen compounds of the Azo dyes saved about 50 per cent of the inoculated mice, and pteroylglutamic acid, a synthetic form of folic acid, also proved effective.

Other compounds tested for their effect against the MM virus were the nucleic acids. Since the polio virus is attracted solely to the nerve cells which are unusually rich in nucleoprotein, the scientists reasoned that the virus' need for this protein might be supplied by another source of nucleoprotein, thus sparing the natural nerve cell substance. Pentnucleotide in [*Continued on page* 64]

Are Uniforms For Street Wear?



"—not seen on the street in uniform, except the natural route of a block or two between hospital and nurses' home? Well, there are abuses of this principle of nursing ethics, but it's not always the nurse's fault," an R.N. said recently in discussing this recurring problem.

Some nursing associations, in questioning a nurse for registry membership, have included the point, "Do you agree not to wear your uniform on the street?"

Practical improvements are called for in many hospitals, if this is to be possible. Many hospitals fail to provide dressing rooms for private duty nurses. There should be some place to dress which is not also shared by orderlies and hospital attendants.

For warranted protection against theft, each nurse needs a locker with a key. One alumnae association did buy lockers for its hospital. However, private duty nurses, who wished to have a locker assigned to them, even though many lockers were empty, were told, "You aren't a staff nurse, so you can't have a locker."

Still another cause for the nurse being on the street in uniform has been the change by which many nurses now buy their meals outside of the hospital. The half-hour lunch period obviously does not allow time to change into street clothes, walk to a restaurant, eat a good meal, and be back in the allotted time. Although most nurses put on a coat, still white shoes and stockings label her, and summer days may make even the lightest coat intolerable.

District associations that wish to restrict nurses' uniforms to professional locations should make direct surveys and see what is needed in the way of dressing rooms, lockers, and hospital cafeterias.

—RUTH B. SCOTT, R.N.

DRUG DIGEST

CURARE THERAPY

(Muscle Relaxant)

PROPRIETARY NAMES: Solution d-Tubocurarine Chloride N.N.R., Solution d-Tubocurarine Chloride (High Potency) N.N.R., d-Tubocurarine Chloride in Peanut Oil with Myricin, Tubarine, Intocostrin N.N.R.

PHARMACOLOGY: Curare, a South American arrow poison has been classified according to its native container—tube, pot or calabash. The purified curare, Intocostrin, and the active crystalline salt, d-tubocurarine chloride, partially block nerve impulses to skeletal muscle at the myoneural junction, producing a flaccid muscular paralysis. Used **experimentally** in polio, curare appears to relieve muscular spasm, thereby enabling earlier institution of phyical therapy. It is also employed to relax muscles during anesthesia, and in shock therapy and spastic conditions. Its use is contra-indicated in patients suffering from myasthenia gravis, kidney disease or any form of respiratory distress.

DOSAGE: Curare is available in 5 cc. and 10 cc. vials, each unit having the activity of 0.15 mg. of d-tubocurarine chloride penetahydrate. Since dosage is determined by body weight, the patient should be weighed carefully during therapy. In manipulative procedures one-half unit per pound of body weight or less is generally administered. Passive exercises may be given about 20 to 30 minutes after administration.

UNTOWARD ACTIONS: The patient should be warned of the general feeling of helplessness caused by curare. Overdosage may result in fatal paralysis. Because of the drug's small margin of safety, neostigmine, its pharmacological antidote, must be instantly available for counteracting respiratory paralysis.

NEOSTIGMINE U.S.P.

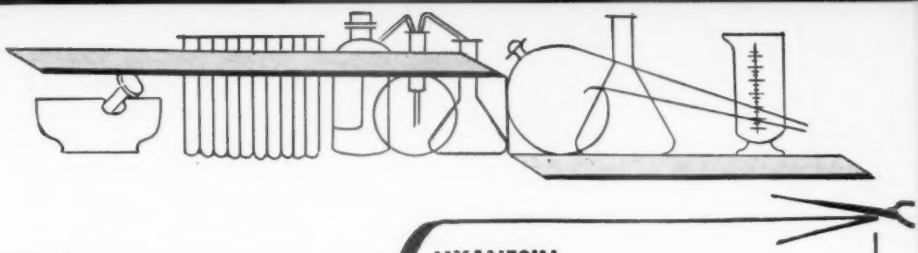
(Parasympathetic Stimulant)

PROPRIETARY NAMES: Prostigmin Bromide, Prostigmin Methylsulfate.

PHARMACOLOGY: Neostigmine, a parasympathomimetic drug, closely related to physostigmine, is used therapeutically in bladder atony, postoperative distention, paralytic ileus and myasthenia gravis. It has also been employed **experimentally** either alone or in conjunction with hot packs in order to decrease muscle spasm and hypertonicity in poliomyelitis, on the supposition that it permits readier transmission of the nerve impulse to skeletal muscles. Its use is contra-indicated in asthma and mechanical intestinal obstruction.

DOSAGE: Neostigmine methylsulfate is available in 1 cc. ampuls of 1:2,000 solution or 1:4,000 solution; neostigmine bromide in tablets containing 15 mg. or 30 mg. The former may be given subcutaneously or intramuscularly in doses of 0.5 mg. to 2.5 mg., and the latter by mouth in doses of 7.5 to 15 mg. for children and 30 to 45 mg. for adults three times daily. In polio, the initial dosage is generally 1 cc. of 1:2,000 I.M. followed by doses at intervals ranging from 0.5 to 2 mg. Atropine may be administered with neostigmine to counteract parasympathetic effects of nausea, diarrhea and urgency. As an antidote for curare overdosage, neostigmine administered intravenously helps to counteract respiratory paralysis. Dosage takes effect about 20 minutes to one hour after injection.

UNTOWARD ACTIONS: Use of neostigmine has sometimes resulted in twitching of face, arms and upper trunk, substernal pain, and emotional distress. The bromide form of neostigmine may cause bromism exhibited by symptoms of acne, apathy, pallor and slow heart rate.



MYANESIN

(Muscle Relaxant)

PROPRIETARY NAMES: Tolserol, Oranixon.

PHARMACOLOGY: Myanesin, a synthetic compound, chemically known as an o-tolyl ether of glycerin, was developed in England during research for drugs which would act like curare without that drug's dangerous toxicity. Unlike curare which produces paralysis by blocking nerve impulses to skeletal muscle at the myoneural junction, myanesin has been shown in some laboratory experiments to effect paralysis by inhibitory action at some point on the motor pathway. It has been used **experimentally** in the acute stage of anterior poliomyelitis to reduce muscle spasm so that affected limbs may have a larger range of motion for corrective physical therapy. It has been reported effective in relaxing muscles of patients undergoing anesthesia and in cases of hemiplegia, spastic paralysis, parkinsonism, arthritis and bursitis.

DOSAGE: Tolserol is available in 0.25 Gm. tablets for oral use, Oranixon in tablets containing 250 mg. and an elixir containing 400 mg. per teaspoonful. The usual dosage is 1 Gm. three or four times a day. Duration of action is brief due to rapid metabolization.

UNTOWARD ACTIONS: Myanesin is less toxic than curare and can effect complete paralysis without stopping respiration. Side effects that have been noted are a feeling of warmth, prickly sensation, slight fall in blood pressure, blurred vision, dry mouth, euphoria, slight muscular incoordination, drowsiness, nystagmus and slowing of heart rate. Respiratory depression may be counteracted by metrazol.

PROCAINE HYDROCHLORIDE U.S.P.

(Local Anesthetic)

PROPRIETARY NAMES: Procaine Hydrochloride, Novocain.

PHARMACOLOGY: Procaine, which has been used for several years as a local anesthetic agent, is the white crystalline salt of a synthetic alkaloid, soluble in water and alcohol. By injection it is capable of producing effective intradermal, neural or spinal anesthesia. It has been administered intravenously for the pruritis of jaundice, burns, arthritis, anesthesia and serum sickness. In 1947 in a study to determine the effects of intravenous procaine in traumatic cases such as sprains, fractures, etc., inflammatory joint diseases and other miscellaneous conditions, it was found that two patients with acute anterior polio who received I.V. dosage showed increased mobility and muscular coordination, and decreased spasm, and two polio patients with vasomotor disturbances experienced warmth in affected limbs. Diethylaminoethinol hydrochloride, a procaine derivative, is now being used **experimentally** in intravenous form for its antispasmodic action, in selected polio cases at Willard Parker Hospital in New York City.

DOSAGE: In the 1947 study, 5 cc. of 20 per cent solution were added to 1,000 cc. of isotonic saline and administered by I.V. infusion drip at a uniform rate over a 20-minute period. Infusions were given two times weekly over a one-month period.

UNTOWARD ACTIONS: Although procaine may be extremely toxic in large concentrations, no serious effects were noted in 2,000 I.V. procaine infusions of the 20 per cent solution. Untoward responses were marked dizziness, trembling, sleepy sensation and unconsciousness.

A GOOD CHANCE for the *RIGHT* PERSON

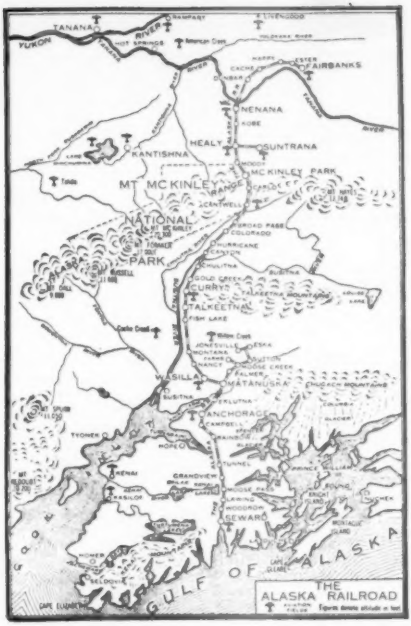
by Marion Bartlett

HOMEWARD BOUND after three years in the desolate Pribilof Islands, Pauline Kerr, R.N. told the freighter captain the question was not *if* she were coming back to Alaska, but how soon she could make it.

"I loved St. Paul!" Her eyes swept past the main Pribilof Island while some 300 Aleuts and 20 whites gathered on the fog-drenched beaches to say goodbye.

But was Miss Kerr's reaction to St. Paul Island a typical response to Alaskan nursing? The question can best be answered by another: Can anything be *typical* in a country stretching over 586,000 square miles, twice as big as Texas?

As vivacious ex-Army nurse Jean Hilchy, who has nursed in Nome, the Aleutians and Anchorage, explained: "You can't compare different parts of Alaska. Climate, scenery, living costs and standards, customs—everything depends on where you are. After all, Juneau is as close to Portland, Oregon, as it is to Nome."



Illustrations from Merle Colby: *A Guide to Alaska, Last American Frontier.* Copyright, 1939 by John W. Troy. Used by permission of The Macmillan Company, pub.

Alaskan nurses, aware that if the territory were superimposed on a map of the United States, it would reach from Mexico to Canada, unanimously advise prospective Alaskan nurses to do careful mapwork and research before investing in a long trip. A nurse who might love historic Sitka in southeastern Alaska's magnificent, rainy fiord country might be miserable in bleak Unalakleet on the Bering Sea.

Despite Alaskan differences, there are certain fairly common assets and drawbacks. On the credit side there is the bracing climate which, as one Army nurse stationed at Fort Richardson's station hospital exclaimed, "makes you feel fully alive. You want to run around at top speed and then eat a huge meal." Only in the rainy

coastal towns is the air relaxing. For sports enthusiasts anywhere in Alaska there are all-year round hunting and fishing (through the ice in winter!), boating and hiking in the summer, and skiing, sledding, snowshoeing and skating in winter.

To the newcomer in particular, the wildlife and scenery is always fascinating and impressive. For those more interested in society than scenery, there is the stimulation of a mixed population. Foreign-born residents, mainly of Norwegian extraction, amount to 20 per cent of the white population, compared to a mere 4 per cent in the nation proper.

The tempo of almost-roadless Alaska, paced to the airplane, is swift and exciting to those temperamentally suited to it. Weather permitting, flying is ideal in the Territory. However, roads are now making a difference in some Alaskan towns such as Anchorage, Fairbanks and Haines.

Vera Liebel, who resigned her nursing position after 11 years with the Alaskan Native Service, flew so much in the line of duty that she became a ferry pilot and now distributes planes for manufacturers. She was the first woman to ferry a plane from the United States to Alaska.

One hunting season, she landed in the wild bush country to pick up a hunter whose side had been shattered by an accidentally discharged rifle. The man was on an Anchorage operating table within an hour of his accident, blessing radios, planes and Miss Liebel.

Most Alaskan drawbacks are the result of the Territory's position at the end of the supply line. Because the cost of goods rises in proportion to the distance they are shipped, living costs, inflated everywhere, are vastly higher in Fairbanks than in Ketchikan.

Difficulties in shipping housing materials plus a soaring population have made housing, tight everywhere, crucially short in the railbelt area (Seward, Anchorage, Fairbanks) where the postwar, military construction boom centers.

In remote areas diets are limited because of these same shipping difficulties and meat, carbohydrate and liquor diets prevail. In Alaskan towns, however, a sufficient variety of basic foods, including fresh fruits and vegetables, are available because of air express facilities throughout the Territory.

Despite this rather gloomy picture, there is a bright side to the economics of life in Alaska. Wages are usually adjusted to inflated living costs and many hospitals provide room and board. But the greatest advantage is not in financial return, but in the sense of feeling necessary.

"You're really needed in Alaska,"

a nurse from Bethel declared. Her hospital is the only one in 250,000 square miles. Too frequently, emergency cases—appendectomies, accident victims, weather casualties—are flown in from surrounding wilderness points.

"The doctor may be visiting one of the neighboring towns when someone with a frozen and gangrenous foot or a gaping gunshot wound arrives. People are so relieved to see you—so grateful. You know you're necessary; but you also know that you need to rely upon your own resources as well."

To the new Alaskan, emergencies seem to occur so often as to be commonplace. The fire hazard—in a land of frame houses, temperamental oil stoves, freezing weather, volunteer fire departments and frequently frozen water mains—is enormous. The Point Barrow Hospital, burned in 1937, was rebuilt in 1939, and the Valdez hospital was burned in 1947. All Alaskan towns have suffered major fire destruction in the past. The town of Nome has been destroyed three times by fire.

Epidemics among the Native population are primarily due to long years of isolation of the Native peoples and the subsequent lack of racial immunity to the white man's diseases. However, control measures promptly instituted do much to prevent real epidemics. In 1946, for example, the incidence of diphtheria increased in central, western and northern Alaska, but early precautionary steps, plus the fact that many

people had been immunized, kept the disease from reaching epidemic proportions.

Mrs. Hal Reherd, R.N., a graduate of St. Mark's Hospital in Salt Lake City, gave up nursing to marry an Anchorage engineer, but was called, none-the-less, to accompany two nurses and two doctors to Unga in the Aleutians where diphtheria incidence was on the upgrade.

"We gave 115 diphtheria shots, lost only three patients, and prevented an epidemic," Mrs. Reherd recalled. She said the medical team brought serum, stoves, cotton, medicine and virtually all equipment with them and sterilized all water used on the island on a little Coleman stove. Cooperation between all the Government and health agencies in Alaska is evidenced by the facts that Mrs. Reherd's services were paid for by the Anchorage Chapter of the American Red Cross; a physician, antitoxin and diphtheria toxin were furnished by the Alaska Department of Health which also directed control activities; and transportation to the Aleutians was furnished by the Navy.

She described the Unga people, part Aleut, part Scandinavian, as "beautiful. They either have big

blue eyes and dark hair or big brown eyes and cornsilk hair. But they know nothing of sanitation or quarantine. One father brought me into a hut full of cots with about ten children in it. He hovered over them. 'Let's see. Somebody has diphtheria. I think it's Jimmy.' "

In pre-war days, before the U.S. Army "opened up" Alaska, emergencies developed such heroic nursing personalities as Mildred Keaton, nicknamed "Buster." She traveled hundreds of miles by dog team in midwinter to bring serum to stricken Eskimo villages. *Collier's Magazine* acclaimed her as the "White Angel of the North."

Such exploits are less common today. Planes fly regular routes over areas formerly served by dog team. Communication has kept pace with transportation. The Department of Health now has a number of marine and mobile medical units reaching even into the most isolated areas of the Territory.

But does modern Alaskan nursing lack color? Hardly!

The larger towns are quite "stateside" with their dress and beauty shops, bowling alleys, libraries, movies, theatres and night clubs.

Anchorage with a population close to 20,000 is the largest city. Its well-equipped 78-bed Providence Hospital compares favorably with hospitals of its size in the U.S.

The hospital on St. Paul Island, on the other hand, is a 12-bed haven, equipped for surgery, but inclined to have all but emergency cases flown inland or to Seattle hospitals. It is operated by the Fish and Wildlife Service. A physician and Miss Kerr are the staff, assisted by two Aleut nurses' aides.

Which hospital—Providence or St. Paul's—offers more satisfying work and true Alaskan atmosphere?

Alaska nurses are almost unanimous in finding the pleasures of responsibility and environment greater in smaller, more remote communities where, incidentally, employment opportunities are also greater.

Contrary to Miss Kerr, Miss Hilchy, although happy in Anchorage, frequently says, "It's not Alaskan enough!"

Many nurses are particularly interested in working with Alaska's three great aboriginal groups: the Indians of southeastern and central Alaska; the Aleuts of the Aleutian Islands; and the Eskimos of the Arctic region.

The famous Miss Keaton is one of many who described the Natives farthest removed from the White Man's influence as being the most attractive.

"Some of the happiest days of my life were spent in Barrow on the Arctic Ocean [*Continued on page* 55]

BOOK REVIEWS

PERSONAL AND COMMUNITY HEALTH by C. E. Turner, Dr. P.H., St. Louis: C. V. Mosby Company, 1948, Eighth Edition. 565 pages, illustrated. $4.00.

The *eighth* edition of this textbook by Dr. Turner, well-known authority on public health and health education, is revised by some new charts, illustrations, and slight changes in chapters on communicable diseases to include latest medical data. The subjects, personal and community health, forcefully presented with their underlying scientific principles, are designed for students of college-level. There are no specific teaching aids but helpful bibliographies and references are given. Appendix A supplies ample material on communicable diseases from the report of the American Public Health Association; appendix B gives important information on disinfection.

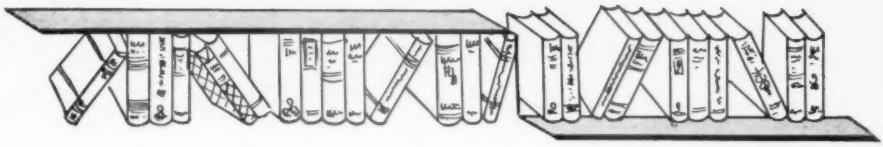
Dr. Turner stresses the fact that health is not merely the absence of disease. It is "attractiveness, courage, and enthusiasm for life." The future of community health depends upon the positive health of the individual. —REVIEWED BY FRANCES LEWIS, R.N., ASSOC. ED.

PRIMARY ANATOMY by H. A. Cates, M.D., Baltimore: The Williams and Wilkins Company, 1948, First Edition. 478 pages, illustrated. $6.00.

This text book for "non-medical" students, written by a University of Toronto professor, describes the human body by systems. While scientific in his approach and scholarly in his presentation, the author has maintained simplicity of expression. Clearly drawn diagrams clarify the text.

Dr. Cates has purposely devoted about one-half the book to the skeletal and muscular systems, in the belief that this will prove adequate for a great number of professional students. This is a splendid plan for those majoring in physiotherapy or physical education. These chapters should provide an excellent foundation for courses in massage and orthopedic nursing for student nurses. A study of the remaining chapters prior to enrolment in an integrated curriculum of nursing should also prove valuable.

—REVIEWED BY HELEN F. HANSEN, R.N.



ASEPTIC TREATMENT OF WOUNDS by Carl W. Walter, A.B., M.D., New York: The Macmillan Company, 1948. 372 pages, illustrated. $9.00.

This monograph, written by a surgical authority, is of value to anyone concerned with asepsis. It stresses the evolution of medical science and serves as an introduction to chemical, mechanical, thermal and physical methods of sterilization by emphasizing the basic principles of each. It describes the destruction of skin bacteria, disinfection of instruments and textiles and air-borne contamination. Attention is directed to results of specific experiments in asepsis and a large proportion of the aseptic procedures are illustrated. The nurse is given a study guide to essential aseptic techniques by means of scientific explanations, accompanied by numerous labeled diagrams and graphs which help to motivate her interest and initiative. *Aseptic Treatment of Wounds* should be a *must* in every central supply room, operating room and nursing library. —REVIEWED BY CLARA H. SCHEITHAUER, R.N.
Instructor of Nursing Arts

LETTERS TO JANE by Gladys Denny Schultz, Philadelphia: Lippincott Company, 1947-1948. 224 pages. $2.75.

This book will prove especially valuable to girls from sixteen to twenty-four years of age, and to their mothers, for it presents sex counsel from a mother to her daughter in a personal, realistic manner through the medium of letters. It should be a useful reference book for nurses, social workers and others to offer to mothers and daughters concerned with these problems. The author attempts to augment the information exchanged at the usual college "bull sessions." Mrs. Schultz says her aim "has been to discuss the emotional aspects of sex for these bewildered young people—things every grown up knows, yet which, for some strange reason, we do not talk over with the ones who clamor for information." This book should be very useful in helping young people to understand themselves.

—REVIEWED BY KATHERINE M. STEELE, R.N.
Director of Nursing Services
California State Department of Mental Hygiene

is there a Test

■ PLEASE ANSWER the following six questions. Only *one* of the five choices in each question is the correct answer. Check the choice you believe to be correct and turn to page 76 for the answers.

1. Which one of the following diseases was the leading cause of all deaths for the last five years as reported by the U.S. Bureau of the Census?

1. Cancer
2. Heart Disease
3. Nephritis
4. Pneumonia
5. Tuberculosis

2. Recent studies have indicated a relationship between certain congenital malformations in newborn infants and virus infections occurring early in pregnancy. This finding was first suggested by a study of the incidence in pregnancy of:

1. measles
2. whooping cough
3. scarlet fever
4. German measles
5. chickenpox

3. An order has been written for a patient to have an intravenous injection of 5 per cent glucose solution. How much water must be added to a 50 cc. ampul of 50 per cent glucose to make the solution?

1. 450 cc.
2. 500 cc.
3. 900 cc.
4. 950 cc.
5. 1,000 cc.

coming into your life?

4. Your hostess has prepared a meal from "cans." To avoid all chance of botulism poisoning, which of the following foods should you refuse?

1. Potted venison in a glass container opened and baked for an hour before serving.
2. Cottage cheese prepared the same day and placed in an open container in the ice box for several hours.
3. Home-canned string beans served in a salad made up a few hours earlier.
4. Pickled gherkins, prepared at home in brine and not heated before serving.
5. Corn, canned at home, and cooked for 45 minutes before serving.

5. Which of the following men died from yellow fever in an experiment to prove that yellow fever is carried by the mosquito?

1. Louis Pasteur
2. Robert Koch
3. Dr. Jesse Lazear
4. Dr. Walter Reed
5. Edward Jenner

6. Under ordinary circumstances, which of the following actions should the nurse take if a postoperative patient in a general surgical ward suddenly complained of pain in his right leg?

1. Encourage him to exercise the leg muscles
2. Apply a snug bandage from ankle to knee
3. Massage the leg and apply heat
4. Elevate the leg and keep him quiet
5. Immobilize the leg and apply heat

by Dorothy Deming, R.N.

Consultant in Public Health Nursing, Merit System Service, American Public Health Association, New York, N.Y.

[*Turn the page*]

On the previous page are random samples of objective, multiple choice questions of the type currently being given by the State boards of nurse examiners for the registration of nurses, in school and college tests and in the civil service and merit system examinations for the employment of nurses. If you have not already made the acquaintance of this type of test, prepare to do so, for more than fifty thousand student and graduate nurses are answering questions of this type every year and more and more employers are requiring written objective tests for applicants to positions and for promotions within the staff.

Fair, impartial, appropriate and discriminating methods of selecting candidates are one of the essentials of good personnel administration and are considered one of the criteria of a well-run merit or civil service system. It is for this reason that the American Public Health Association has been so much interested in supplying civil service and merit system agencies with authoritative testing materials. Its project, now seven years old, covers all of the professional fields of public health and the staff has prepared more than six hundred examinations, of which 170 have been for nurses. Other agencies preparing tests for nurses on a nation-wide scale are the Committee on Measurements and Educational Guidance of the NLNE, the Psychological Corporation and the U.S. Civil Service Commission. So the chances of your taking an examination in the immediate future are strong!

Many people ask: why do I have to take a written test before qualifying for a job when I am a registered nurse, have taken a state board examination and have had all the necessary experience and training called for by the job specifications? The answer is that there are several reasons why a written test is fairer both to the applicant and to the prospective employer.

From the applicant's point of view, a written test presents a chance to compete with other nurses who may have had more years of experience, or degrees, or variety of jobs, yet have not acquired knowledge. Your score on a written test is irrefutable evidence that you either do or do not know the appropriate body of facts which you will use in your job. The test gives you a chance to outscore a veteran if you do not have veteran's preference. It can establish your position as a well-prepared applicant even in the face of others who may be depending on political or social "pull." There can be no favoritism shown in an open competitive objective, written test, machine-scored. It may save you repetitious study during the period of your introduction to a new position, or, on the other hand, such a test may show you where you need to brush up your knowledge. An objective promotional test gives you a chance to lift yourself into a higher salary bracket, an opportunity that might not come your way if the staff is very large and no effort is made to develop a true career service. Appli-

cants should really welcome tests. If a test does not appear fair to you, you have, under merit system rulings, the right to appeal and state your objections to the examining body.

Putting yourself in the place of the employer, imagine that you are looking for a supervisor. You have in all, 10 applicants, two of whom are known to you personally, two of whom come highly recommended from friends, two of whom are from very large hospitals, two from small but good hospitals and two from out of the state. All qualify as to age, state registration, basic preparation, graduate study and job experience. How will you select just one? What tool will be most dependable as a means of selecting and differentiating between the better and poorer candidates and how will you place them in rank order? There are three usual methods. You can "rate" their past training and experience, checking against an objective scale of values—for instance, giving the nurse with a college degree more points than the high school graduate, etc.—you can interview each nurse, preferably at a conference where there are three or four qualified persons scoring the interview against a rating scale. But even these two methods may leave you thinking four of these nurses are good and three have great possibilities—but which is the best, first choice? Let us say the position is in the out-patient service of the hospital. Would you like to know which of the 10 nurses really knows how to handle the problems there? Would you like to find out whether the nurses whom you think are "good" know the basic principles of supervision [*Continued on page* 72]

Probie

"Look noble."

REVIEWING THE NEWS

▶ A MARCH OF DIMES grant of $18,500, based on the premise that polio patients need adequate nursing care, has been awarded to the Committee on Careers in Nursing, which has assumed responsibility this year for the national nursing recruitment program.

▶ THE DOCTORS' CODE, outlined in Principles of Medical Ethics and revised without attending newspaper publicity at the AMA's last convention, now states that a physician wishing to present medical material to the public should request approval from his county medical society; that the promising of radical cures or boasting of professional skill is unethical; that contract practice is ethical provided its provisions do not cause deterioration of quality of medical services; and that a physician shall not use his professional services or attainments for the financial profit of a corporation or lay agency. This code has been officially recognized by Government courts as a guide to physicians in the practice of their profession.

▶ HEWING to their middle-of-the-road policy on medical care plans taken in 1946, the ANA and NOPHN recently declared that they "as organizations, do not support or oppose legislation to establish compulsory health insurance." Leaving the choice of medical care plans up to the consumer and the individual nurse, they further state that "the nursing profession must accept the responsibility of providing necessary nursing services in any medical care plan which is established and supported by the general public or by any special group or groups within the public. Non-acceptance is sanctioned only when a plan does not contain safeguards to insure high quality of nursing services . . . The expansion of medical care plans with all necessary nursing service, including nursing care in the home, should be encouraged. In addition to voluntary effort, Governmental assistance is necessary for attaining adequate distribution of health services."

▶ ABOUT PEOPLE: *Mrs. Margaret Lucal* of Willoughby, Ohio, treasurer of the American Association of Industrial Nurses, has been appointed one of the 10 members of the newly established USPHS national advisory committee on problems of industrial hygiene . . . *Sara Abrams*, former lieutenant colonel, ANC, and assistant director of the Illinois School of Psychiatric Nursing at the Chicago State Hospital, has been appointed director of nursing at the Illinois Neuropsychiatric Institute which offers affiliation in neurological and psychiatric nursing to nursing schools in the state . . . Foresighted *Nellie*

Brown, nurse superintendent of Ball Memorial Hospital at Muncie, Ind., faced by a shortage of iron lungs and an increasing number of polio admissions, delegated a local inventor to construct an iron lung according to plans in a magazine article. In about ten hours, the iron lung, made of alcohol barrels, plywood, a vacuum sweeper and other odds and ends, was being used by a young polio victim.

▶ A BOOST for aid to medical education was given by the Senate Labor Committee which approved the bill authorizing grants totaling $250 million over a five-year period to schools of medicine, osteopathy, dentistry, advanced nursing, basic nursing and dental hygiene.

▶ A TRI-STATE regional conference of industrial nurses sponsored by the Philadelphia Industrial Nurses' Association, the New York (City) Industrial Nurses' Club, and the New Jersey Industrial Nurses' Association will be held at the Hotel Sheraton, Newark, N.J., Saturday and Sunday, October 29-30. Nurses employed in these areas and Delaware are urged to be present. The theme of the meeting will be "The Education and Advancement of the Nurse in the Industrial Nursing Field." Those who wish to attend should contact the president of the industrial nurse group in their area: Eleanor Hoover, president, Philadelphia Industrial Nurses' Association, c/o Abbott Dairies, Inc., 31st and Chestnut Streets, Phila., Pa.; Ella Casey, president, New York Industrial Nurses' Club, c/o McCrory Stores, Inc., 1107 Broadway, New York 10, N.Y.; Mrs. Lena Lyons, president, New Jersey Industrial Nurses' Association, c/o American Type Founders, Inc., 200 Elmora Ave., Elizabeth, N. J.

▶ TWO GRANTS totaling $16,934 have been awarded by the National Cancer Institute, USPHS, to Columbia University Teachers College and the University of Minnesota for the purpose of instructing clinical teachers and public health nurses in the latest nursing procedures and developments in cancer.

▶ A DISTINCTIVE UNIFORM for members of the Michigan Practical Nurses Association has been approved by the Michigan Nursing Center Association and other professional nurses. The official uniform consists of a white cap with wide cuff banded in gray, white dress, insignia on left sleeve—"Michigan Practical Nurse," white shoes and hose. Sale of cap and insignia are carefully restricted to members in good standing.

From the looks of things, Bob's FLOWERS-BY-WIRE will help . . . as Grace becomes so bright and happy.

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Easy Hospital Room Delivery

Most F. T. D. members deliver FLOWER orders in vase containers filled with long-lasting, chemically treated water.

FLORISTS' TELEGRAPH DELIVERY ASSOCIATION, 149 Michigan Avenue, Detroit 26, Mich.

A Good Chance

[*Continued from page* 45]

is the sincere opinion of Mrs. Ed Arnell, R.N., a graduate of St. Elizabeth's Hospital in Washington, D.C., who retired to marry an Alaskan attorney. "The happy, friendly, unspoiled Eskimos were such fun! Lots of little Barrow girls are named for me. Off duty we nurses went dog-sledding far out on the ice to watch whale hunters bring home the blubber. I was fascinated too by the reindeer corrals. When I heard the Navy was going to develop Barrow as a big petroleum base, I was sorry."

There are approximately twenty-five hospitals in Alaska, most of them run by religious groups. Forty-seven physicians and surgeons are listed in the business section of *Who's Who in Alaska*. There are five private clinics, two of them in Anchorage.

Nurses may be hired independently by institutions or by either of the two Government agencies, the Alaska Native Service, part of the United States Office of Indian Affairs, or the Alaska Department of Health.

The Alaska Native Service engages primarily institutional and public health nurses on a diminishing basis.* They occupy itinerant stations in the Interior and the North. The agency operates six small general hospitals and Mount Edgecumbe Medical Center near Sitka which is composed of a Tuberculosis Sanatorium and an Orthopedic Hospital. Qualified public health nurses are stationed at each of the three Native Boarding Schools.

The Alaska Department of Health is gradually assuming responsibility for all public health nursing service and employs most of the public health nurses in Alaska. In southeast Alaska, last year, the Alaska Native Service contracted with the Department of Health for public health nursing services to all Native villages in southeast Alaska. In addition to present stations as far north as Fairbanks and Nome, and as far west as Kodiak and Naknek, this year the Department of Health plans to extend public health nursing service to Point Barrow, Bethel and the Aleutian Islands area.

Minimum requirements for public health nurses are completion of an approved course of study in public health nursing and at least one or two years' supervised experience in a generalized public health program. Among 40 public health nursing stations there are usually vacancies for well-prepared nurses.[1]

All nurses must be licensed by the Board of Nurse Examiners in Juneau when employed for work in Alaska.[2] Any graduate professional nurse registered in the U.S. is eligible for an Alaskan license.

Nurses with specialized training in tuberculosis care are frequently needed in the two sanitoria at Seward and Mount Edgecumbe. The

*For information, address General Superintendent, Alaska Native Service, Juneau, Alaska.

1. For information, write Director of Public Health Nursing, Alaska Department of Health, Juneau, Alaska.

2. Federal nurses are encouraged to secure licenses in the Territory.

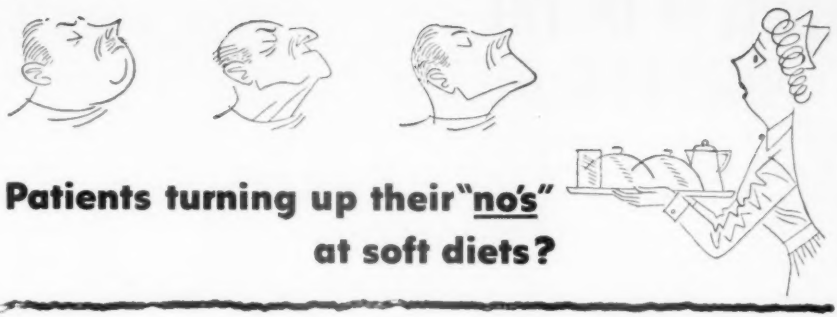
Tb. death rate in Alaska is nine times as high as in the U.S.

This is important. Hospitals and agencies are particularly interested in *permanent* employes. "Tourist nurses are discouraging. They stay long enough to see the place, then push on for more sight-seeing," hospital administrators complain. "Or maybe they stay a month and decide they hate Alaska. Investigation of conditions beforehand would have saved them the trip."

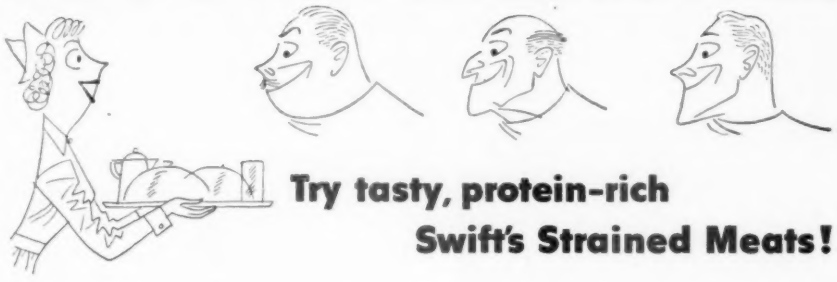
But what future does Alaska offer permanent candidates?

As the Federal Government continues to pour millions into the defense of Alaska, the Territory's immediate future is bright. Hundreds of would-be settlers roll north in a continuous stream over the tortuous Alaska highway. Both the Alaska Native Service and the Alaska Department of Health are expanding. The latter agency launched mass chest x-rays a few summers ago, eventually to cover every Alaskan city. Such health services as the chest x-rays, BCG vaccinations against tuberculosis, dental care and emergency medical service are now brought on an itinerant basis to more remote areas in the Territory by special land and marine units which consist each of a doctor and nurse, usually a dentist and laboratory technician, and a clerk. The 114-foot *M/ S Hygiene* and the self-propelled ocean barge operate the year around along the coastline of Alaska from Ketchikan to Kotzebue, just above the Arctic Circle. Other units operate seasonally. The Yukon River barge, whose service begins this year, will ply the Yukon and Kuskokwim Rivers; a mobile truck unit operated during the summer months along the Interior Highway System from Fairbanks to Valdez and the Canadian border; and a Railroad Unit for the Alaska Railbelt area is furnished by the Alaska Railroad for the Department of Health.

The Federal, territorial and communal governments, private agencies and individuals have all developed sensitive consciences over the tragic plight of the Alaskan Native. Before the coming of the white man, the aboriginal suffered only a fraction of what he suffers today from tuberculosis, venereal disease, tooth and



Patients turning up their "no's" at soft diets?



Try tasty, protein-rich Swift's Strained Meats!

Palatable, natural source of complete, high-quality proteins for patients on soft, smooth diets

To help overcome anorexia many doctors now recommend Swift's Strained Meats. Delicious, *real* meat that patients on soft, smooth diets can eat and *enjoy*. Swift's Meats provide an excellent base for a high-protein, low-residue diet. Rich in iron, they're chemically and physically non-irritating. They make *all* the essential amino acids available *simultaneously* for optimum protein synthesis.

Swift's Strained Meats are tasty enough to tempt tired appetites. They supply goodly amounts of B vitamin to help stimulate patients' natural appetite for other foods. Swift's Strained Meats are 100% meat—a variety of six kinds: beef, lamb, pork, veal, liver, heart. Originally prepared for infant feeding, they're exceptionally fine in texture—may easily be used in tube feeding.

The makers of Swift's Strained Meats invite you to send for your copy of "The Importance of Protein Foods in Health and Disease"—a physicians' handbook of protein feeding, written by a doctor. Send to:

For patients who can take foods of less fine consistency—Swift's Diced Meats—tender morsels of nutritious meats. Tempting flavors patients appreciate.

SWIFT & COMPANY
Chicago 9, Illinois

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eye trouble and other afflictions.

Government and charitable organizations have made tremendous efforts in recent years to help the Alaskan Native with appropriations and studies. Seven specialists from Chicago's Cook County Hospital, representing the American Medical Association, made a flying tour of Alaska at the request of the Interior department and promised to urge greatly increased appropriations. They described the Territory as "seriously understaffed" with medical personnel.

A critical shortage of hospital beds puts heavy stress on preventive medicine in Alaska. Inoculations, case finding, early treatment, home nursing and health teaching are important R.N. responsibilities in smaller communities and in field work.

So much for the immediate future. As to long-range prospects, after international excitement subsides, the trend points to a fairly stable, permanent population, but nobody can be certain that today's widespread interest in Alaska will not burn itself out, leaving the huge territory almost as empty as before the last war. Alaska's destiny is a favorite topic, with opinions ranging from that of extreme optimism (statehood) to extreme pessimism.

However, one thing is sure: Alaska always has and always will need good doctors and nurses, and to those professionally and temperamentally qualified the Territory offers commensurate rewards.

[A list of hospitals in Alaska is available upon request. THE EDITORS]

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only MIDOL contains the *exclusive* anti-spasmodic, cinnamylephedrine

Effective analgesic and anti-spasmodic medication with mild stimulation forms an essential part of the successful symptomatic management of dysmenorrhea.

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Polio Nursing

[*Continued from page* 36]

There was one little boy who was completely paralyzed except for his fingers; he wouldn't eat and was growing thinner and more apathetic by the day. It occurred to Miss Busby that he might be able to feed himself in the wheel chair if his arms were placed in splints. To everyone's delight this procedure worked. Immediately his appetite perked up and mealtime became something to look forward to. Soon he was able to manipulate the wheels of his chair with his toes and roll himself about the ward.

Whenever possible, children get out of bed to eat their meals at small tables with a nurse beside them to lend encouragement. The theory of leaving a child alone when he refuses to eat doesn't apply to most little polio patients, according to Miss Busby. Leave them alone and more than likely because of their weakened physical condition their appetites will dwindle to nothing. Since they haven't the stimulus of fresh air and sunshine, it helps if mealtime is fun. There was one little girl who wouldn't drink her milk until one of the nurses placed a glass before her containing a bright-colored straw. From that time on, her milk glass was emptied. A little thing, perhaps, but important to a child desperately in need of nourishment.

A stranger entering the polio convalescent ward at Mercy Hospital is astonished by its cheerful

No one would know she had a Mastectomy

her Spencer Breast Support with Breast Form

restored normal appearance

The patient pictured here had a Spencer Breast Support designed especially for her. Into the breast pocket is fitted a soft, light, porous, washable breast form sculptured to an exact likeness of the natural breast. Each Spencer is created especially for the wearer.

If *your* problem is sagging breasts

we shall design a breast support *just for you* to hold your breasts in a position to improve circulation, and thus aid nature to restore tone of tissues.

Send coupon at right for free information or look in telephone book for "Spencer corsetiere" or "Spencer Support Shop".

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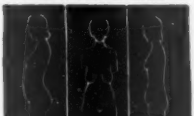

Lordotic Posture *Breast Problems* *Ptotic Posture*

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® FOR ABDOMEN, BACK AND BREASTS

atmosphere. For one thing, it is hard for the average person to remember that only from 15 to 25 per cent of polio cases are severely handicapped and that between 40 to 60 per cent leave the hospital with no visible evidence of the disease. The majority of the patients are not too encumbered with braces or other apparatus, and many don't even look ill.

"In this ward," says Miss Busby, "the children share in a community life, and for those who haven't learned at home to give and take it is always an enriching experience. When one patient receives a gift, all of them enjoy it. There's a community bank in which parents and friends drop nickels and dimes and that bank is always emptied, by unanimous consent, for a birthday occasion. There are whistles, balloons, games, and gifts for the birthday child, and one of the stores generally provides the cake and ice cream."

State authorities aroused by what may prove to be one of the nation's worst polio years are now making plans to provide facilities like those of Mercy Hospital in other parts of the state. They also hope to induce general hospitals to open their doors to polio victims as they do to other contagious patients. This would take some of the burden off the Vicksburg nurses. However, until that time nurses and aides under the able direction of Ethel Busby will continue their hospital's special task of nursing polio patients back to health and happiness.

When the problem is Pediculosis Capitis

Here's how to solve it *Tactfully*

It is embarrassing to the nurse when a parent must be told that a child has lice. Here's how to get around it gracefully, and win the gratitude of the mother.

Send for a supply of the little leaflet prepared by the makers of A-200 Pyrinate Liquid. It is addressed to parents, and tells in sympathetic and diplomatic language the actual *danger* of lice infestation. It also tells these things about A-200:

A. A-200 is a sure, fast killer of lice, and their eggs . . . on contact. One 15-minute application is usually sufficient.

B. A-200 is non-poisonous, non-irritating, and leaves no tell-tale odor.

C. A-200 is easy to use. It is a liquid . . . no greasy salve to stain clothing. Especially recommended for children. At all drugstores, only 79¢.

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McKESSON & ROBBINS, INC., Bridgeport, Conn.
Please send me a supply of the leaflet, "Pediculosis Capitis is *dangerous.*"

Name_____

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City_____ Zone____ State_____

Polio

[*Continued from page* 38]

addition to yeast nucleic acid has protected two-thirds of infected mice. In another series, dosage of the drug given *after* infection prevented deaths or paralysis in 45 per cent of the mice, indicating that nucleic acids may exhibit definite antiviral and curative as well as prophylactic properties. These substances may next be used experimentally against polio viruses in animals.

Experimentation with drugs has not been confined to the prophylactic and curative aspects of polio. Research is also under way on drugs which may have value in the treatment of the disease. At this preliminary stage, the four drugs discussed in *Drug Digest* must be regarded simply as experimental adjuncts in the care of the polio patient. Many authorities do not subscribe to their use in polio but since nurses may have occasion to use them in certain hospitals, they may be interested in knowing some of their pharmacological properties. In any case, they will want to give an account of these drugs to the public which may be misled by exaggerated stories of poliomyelitis cure-alls.

Research in any disease builds slowly, block upon block. Polio research is no exception. Perhaps it will not be too long before "the drug" will emerge from the long and arduous work of polio researchers, and poliomyelitis epidemics will become a scourge of the past.

[Bibliography available upon request.—THE EDITORS]

You know, you do more for your patient than you might think . . . .

For instance, your crisp clean uniform and your air of confident grooming go a long way to brighten your patient's day.

But good grooming is more than the morning bath and a bright fresh uniform. Because perspiration is a continuous process.

MUM is the safer way to preserve morning bath freshness. You'll love its delightful new floral odor, its creamy texture. And MUM is sure because it prevents underarm odor throughout the day or evening. Recommend it to your patients too.

Why take a chance when you can MUM in a moment?

Safer for charm . . .
Safer for skin . . .
Safer for clothes . . .

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Candid Comments

[*Continued from page* 31]

nine out of ten, that in any other similar job I'd run right into the same kind of situation."

How common this kind of situation is no one knows. Diligent inquiry strengthens my belief that it is much too common. Some of the fault lies with directors who are afraid to meet boards or who have not worked out precise plans for presentation, or who lack the courage of conviction. Much of the fault I believe, however, lies in the attitude that "nurses only work here" and with boards unaware of responsibility for nursing and to nurses.

It is true that in some of our strong institutions the nursing director does have authority commensurate with her responsibilities and that she does have direct contact with the board of directors. But the trend in this seems tragically slow while the need for it grows by leaps and bounds. Nursing administration today even under the best of circumstances is one of the most difficult in the whole category of jobs. Under less favorable circumstances it calls for actual heroism and needless sacrifices.

"Time's a wastin'." Can we wait to be invited into the councils or shall we in the interests of patient care invite ourselves in? We can pour money and personnel into hospital administration, but until nursing achieves its full stature as an operating partner, can any lasting progress be achieved?

When patients ask you about **tampons . . .**

So that you will know the true facts about Meds, the Modess tampon, Meds has prepared a booklet "It's So Much Easier When You Know," which answers questions like these:

What are Meds?

Meds are small tubes of soft, white, highly absorbent cotton. Meds are safe, designed by a doctor to approved medical standards. They are worn internally to absorb the menstrual flow—thus there is *no odor*—with Meds you stay fresh and clean every day of the month.

How are Meds inserted?

Here's where patients may need your help. Correct insertion is simple, though important. Each Meds comes with its own smooth, glazed sanitary applicator. The outer tube slides easily into the vaginal opening. The inner tube pushes the tampon gently into place above the sphincter muscle, which holds it firmly until it is removed. The improved applicator cannot come apart. Meds are the safest, surest, most comfortable method of sanitary protection ever known.

When can I first use Meds?

Any normal woman, married or single, can use Meds as soon as she is fully grown, when the vaginal opening will admit a tampon without difficulty. Meds come in three sizes, Junior, Regular and Super, to fit individual needs. Some women like the added protection of Meds *and* Modess for the first few days.

The advantages of Meds?

Meds are comfortable. You won't know you're wearing one—*and neither will anyone else.* Meds give you absolute freedom of action, no bother with pins, pads or belts. Meds are the daintiest method of keeping fresh and clean, living a normal life *every* day. Doctors appreciate their psychological advantages. Clinical research by reputable gynecologists has proved their safety. And there's no disposal problem—Meds simply flush away.

So that you will know about Meds yourself, and will be able to tell your patients about this new and better method of sanitary protection, we invite you to send for your free professional sample of Meds in plain wrapper, and Meds' new free educational booklet "It's So Much Easier When You Know." Write today!

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Yes, I would like to try Meds and read your educational booklet. Please send samples and booklet to

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Position _____

Address _____

City _____ State _____

Can You Run A Home?

[*Continued from page* 33]

if my husband wanted a steak or chops, he was willing to play chef.

Since my family likes cold fried chicken, I often prepared it in the morning and made potato salad to go with it. These were kept in the refrigerator until time for the "bachelor" dinner at night.

All this may indicate that my life in recent years has been all work and no play, but this is not so. By budgeting my time, I actually found myself going more places then when I had the single job of a housewife. I go shopping in the morning when the stores are not crowded and the clerks have time to wait on me. I sometimes go to a movie at a theatre in our town which opens at noon. I can also get an early morning appointment in the beauty parlor.

One fact is undeniable. I do not have as much time to spend with my family and husband as I once did. However, Sunday is my day off and then we make up for lost time. In fact, there is more real enthusiasm within the family circle, because now we do not have time to get on each other's nerves.

When I returned to work my daughter was almost an adult. My son was not. But he is now 18 and I don't think he has suffered at all from this arrangement. He always came home from school at noon and I prepared a hot lunch for the two of us. He was out of school at three o'clock and, since my husband returned home soon after five, there

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Here is a way to make daily tooth brushing a pleasant experience instead of a chore:—tell your patients to use Kolynos. The smooth creamy consistency of Kolynos, the refreshing minty flavor, invite patient cooperation in adults and children alike. Kolynos leaves the mouth feeling cool and clean, actually makes teeth brighter when due to improper cleansing. Next time one of your patients asks, "What dentifrice should I use, doctor?" why not suggest, "Kolynos".

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were only two hours when he was without a parent.

Rather than hurting family relationships, my working has in many ways helped me to become a better mother as well as a better nurse. At the hospital I am constantly working with student nurses who are a few years older than my son and almost exactly my daughter's age. Many of these girls are away from home and confide in me as they would in their own mothers. I am kept up to the minute on their latest loves and the latest styles. They tell me their plans and ask my advice. All this has given me a greater understanding of my own children and their problems.

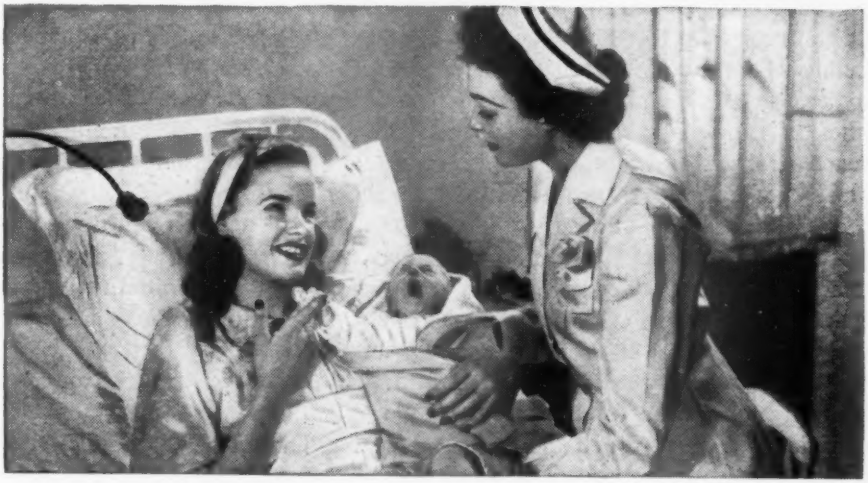
The benefits of my return to nursing do not stop with my own family and the hospital. I am a better groomed, better poised person than I was. As a result of my constant contact with doctors, other nurses and hospital visitors, I meet my husband's business associates more easily. My range of interests is wider.

Much of the project's success hinges on the willing cooperation of my children. Now they are prouder than ever of their mother. My daughter, whose college expenses were responsible for my return to work, was graduated two years ago. Our mother-daughter relationship is closer than it has ever been.

I have been successful at the hospital. My salary there has been regularly increased, and I now supervise the pediatrics ward for five of my eight hours on duty. In short, my family and I have dubbed the whole experiment a great success.

Infant skins treated with lotion*were smoother . . . softer . . . exhibited fewer irritative rashes

(as reported in American Journal of Diseases of Children)



In evaluating the effectiveness of certain preparations for infant skin care, 2077 newborn infants were observed in a large Chicago hospital.

Over a two-year period, Johnson's Baby Lotion was used for routine skin care. Incidence of miliaria showed a dramatic drop from a high of 55% (before use of lotion) to a low of 3% (with lotion care).

Johnson's Baby Lotion is specially formulated to agree with infant skin. A homogenized oil-in-water emulsion, it leaves a discontinuous film, permitting normal heat radiation and allowing free transpiration of insensible water loss.

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Please send me, free of charge, one sample bottle of Johnson's Baby Lotion.

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Limited to nursing profession in U. S. A.

—is there a Test?

[*Continued from page* 51]

and something of elementary teaching, especially health teaching? A written test of 150-200 questions, taking about two and a half hours to answer, will rank these 10 applicants. Then you can take your scores from the rating of training and experience, the scores from the oral interview and the written test and see how your candidates line up. Most examiners place most reliance on the written test, allowing it a weight of from 40-65 points out of 100; training and experience: weight 15-40; with the interview—considered rather unreliable as a selective device—assigned 15-30 points. Of course, this three-part method of selection is not infallible. All of us know from sad experience that book-knowledge, appearance, and "wonderful experience" may not combine to make a successful supervisor. Your best scoring candidate may not be able to get along with people, but the chances favor a wise selection when using these methods and their fairness cannot be denied.

It is as well to point out here, that the administrator's fourth and most reliable measure of worth—which deserves a chapter to itself—is the probationary period during which the applicant for permanent appointment tries to show in her actual work that her choice was a wise one and the administrator watches to see if her selection is justified.

Can a written test help select a person who is applying for a position in which judgment, initiative, imagination and common sense are more essential than clinical knowledge of nursing procedures? Yes, it can *help*. Questions which measure judgment can be devised. For example, one might ask this, "A supervisor is faced with an unexpected shortage of personnel in the out-patient service. She will have two nurses to cover the four clinics in session. Which one of the following ways should she adopt to meet the emergency?" Or, "A patient asks a student nurse to accept a rather expensive present, saying she knows it is against the rules for the student to accept. What should the student do?" Can you, reader, con-

struct five choices for each of these questions only one of which will fit each case correctly?

There are also other ways to assist in selecting applicants for the administrative positions, such as essay questions, written assignments which require a candidate to assemble her thoughts and facts in logical order, or group interviews in which controversial problems are discussed, situations presented and the candidate asked to outline several different approaches pertinent to the fundamental problem involved—but these methods have disadvantages.

One of the great advantages of objective questions is the range of subject matter which can be sampled in a short time. To ask a student to write her answer to this request will take her at least 5 minutes—"What are some of the common discomforts of pregnancy?" But you can get to the heart of the matter by requiring a pencil stroke after the correct choice to the question: "Which one of the following discomforts of pregnancy should be reported to the doctor immediately?" The rest of the 5 minutes can be used for four *other* questions about prenatal care!

Another advantage of this type of test is that the wrong choice may reveal a weakness in related knowledge so that a nurse who selects the choice—"lack of protein in the diet" as the most frequent cause of baldness, reveals not only her ignorance of our slight knowledge of the causes of baldness, but also her confusion in her knowledge of nutrition.

Objective tests can be scored by machine at the rate of one test every few seconds which is another marked advantage over essay questions, especially with hundreds of candidates taking a test. But the time element mounts at the construction end of the line. It takes anywhere from 10 minutes to two hours to compose a really fair, well-balanced and difficult objective question. The more the element of judgment enters into the answers, the longer it takes to construct the questions. In the best testing services, the responses to each question are analyzed over a series of many tests given to many different groups of nurses until it is discovered just how difficult each question really is, whether it is well-constructed and, most important, whether it is differentiating between the nurses

who are making high scores in the test in which the question appears, and those receiving low scores. Naturally, if a question is missed by everyone taking the test, it is much too difficult for the group or else is a bad (perhaps unsound) question. If everyone answers a question correctly, that question is no good as a discriminator in that test. The test as a whole or parts of it can also be validated against success under actual working conditions in the job.

As the American Public Health Association builds up its experience with the thousands of questions in its files—there are more than three thousand nursing questions alone—and every test is subjected to the statistical analysis indicated in the preceding paragraph, it is evident that the written test can serve a wide variety of purposes. Currently, the Merit System Service tests are being used by colleges and universities, by state licensing boards—(not nursing)—by civil service and merit system agencies for entering and promotional examinations on state and local level, by visiting nurse associations for in-service programs and guidance, by the United States Public Health Service and by a specialty board of the American Medical Association. Many a nurse has sampled her own ability to answer questions by helping to review questions and a few have undertaken the not-easy task of writing questions in the general and special fields of nursing. Recruits for the latter job are always welcome.

So if the shadow of a written objective test falls across your path, you may be sure that you are not alone in the experience and that far from being an ordeal, you will probably find the test an interesting and worthwhile way of assuring you of fair consideration. The ultimate aim of a good testing program is, of course, to raise the standard of nursing service to the public through the employment of those who qualify on merit rather than through pull. To quote an axiom familiar to those in the testing field—"Civil service administration can rise no higher than its source, which is the competitive test."

Answers to the six questions on pp. 48-49

1. Choice 2
2. Choice 4
3. Choice 1
4. Choice 3
5. Choice 3
6. Choice 4

Typical nurse's uniform 1865

Styles change...

but surveys show
nurses ***still*** prefer:

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GRIFFIN ALLWITE

R.N. Speaks

[*Continued from page* 27]

Monarch and Pipestem Butterflies," to watch a style show? This isn't far fetched or meant to amuse. We could put down a dozen more similar examples chosen at random from various district and state bulletins. A veteran nurse who for years has struggled to focus nurses' thinking on issues says, "No other profession's programs wander into so many unrelated and incongruous paths as do ours. We don't seem to realize that our meetings should be the professional highpoints of the month. We waste too many on entertainments and nonessentials."

It is our opinion that no amount of exhortation or crying for larger attendance can overcome the deadly combination of two hours of committee reports, lots of little discussion over little points, followed by lectures of only passing interest, read by speakers, jittery from the long wait, who talk to their top vest buttons.

Don't blame the program chairman! That is a thankless job. Before we as nurses get our money's worth from our meetings, all of us have to realize first what meetings are for. We have to realize too that yesterday's pattern is all out of kilter with today's needs. We must decide that group decisions such as we have been called upon to make need first, group discussion, and this calls for a pattern quite different from that of the past.

Let's take the district or alumnae meeting for example. These are our most productive meetings in the long run because: (1) They are a cross section of nursing interests and nurses at work; they are close to the realities of life; theorists don't thrive well here. (2) The average nurse is more at ease in this familiar atmosphere; therefore, she is more apt to speak up in meeting here than in a national or state meeting, and her experiences and opinions must be a part of the final decision for she is the root of the nursing profession.

How can these meetings yield the highest returns? The planning of the program is important. We can't have a well coordinated, challenging, vital and interesting series of district or alumnae meetings until we have a

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Doctors smoke for pleasure, too! When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

long-range program of objectives—a program planned according to a central theme. Such a program cannot be successful in one single meeting. Speakers should be chosen to fit the program, not the other way around. The advance publicity should build up the subject, not the speaker, as is more often the case. Meetings should be divided into both formal lectures and group conferences, with increasing emphasis on group participation. This might eliminate that all too frequent perceptible void between the speaker and a passive audience which spells doom for any meeting. However, there are good ways and poor ways of conducting group conferences, and even though we do adopt the popular group-dynamic method of meetings, so long as our basic faults prevail the results will be the same. Our present situation could be likened to the old-fashioned prayer meetings—those souls who believed themselves saved kept coming back for more—the sinners stayed away. Why? —ALICE R. CLARKE, R.N

Because of this year's mounting polio incidence which so far has exceeded that of the same date in 1948, the worst polio year since 1916, all nurses who have had polio nursing experience or who are available for possible polio assignments are urged to enrol with their local Red Cross chapters. The Red Cross polio nurse recruitment program aims only at supplying nurses for emergency areas; all salaries, transportation and maintenance are paid by the National Foundation for Infantile Paralysis.

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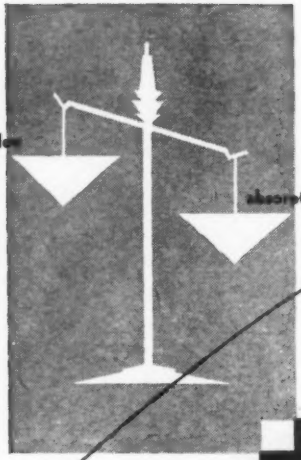

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*Am. J. Obst. & Gyn., 31:979, 1936.

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ADMINISTRATOR: Community hospital, general, serving several towns. Small town located short distance from university medical center. Two hours' drive from Chicago. $4,000, maintenance. RN9-1 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANATOMY-PHYSIOLOGY INSTRUCTOR: $300. Large hospital, eastern college town. (N103) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETIST: Privately-owned hospital, general. Patient average, 100. Considerable surgery. All-graduate staff. 5 day week. $265-$290 basic, with $50-$100 overtime compensation. Pacific Coast. RN9-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETIST: 5 day week. $300. New, modern surgery 60 bed hospital. Southwest. (N443) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETIST: Clinic staffed by fifteen specialists, university town of 50,000. Middle West. $350-$450. RN9-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETIST: Teaching and supervision. 40 hour week. University hospital. Midwest. $325. (N415) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETIST: 150 bed hospital, southeastern resort area. $400 (N366) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETIST: $400. New 150 bed hospital, new equipment. Midwestern university town. (N445) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETIST: New York City suburb. Approved 200 bed hospital. Full maintenance. Attractive salary. Apply United Hospital, Port Chester, N.Y.

ASSISTANT NURSING DIRECTOR: $300, maintenance. 400 bed hospital. Great Lakes Region. (N143) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

CLINICAL INSTRUCTOR: $300. Western university hospital. 50 bed psychiatric unit. (N155) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

COLLEGE NURSE: First Aid. Some health education work. Chicago Area. Degree required, $250. (N314) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

DIETITION: New 150 bed tuberculosis sanatorium. Great Lakes Region. $300, maintenance. (N549) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

DIRECTOR OF NURSES: General hospital, nearly 400 beds. Student enrollment, 100. Excellent teaching facilities and class rooms in new modern nurses' school and residence. Eastern metropolis. RN9-4 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTOR OF NURSES: Orthopedic hospital presently under construction. All-graduate staff. University town, 185,000. Midwest. RN9-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTOR OF NURSES: $4800. Modern, fully-approved hospital, New York resort community. (N543) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

DIRECTOR OF NURSES: Voluntary hospital, fairly large size. School considered one of leading in California. Excellent faculty. $5000-$6000. RN9-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTOR OF NURSING EDUCATION AND SCIENCE INSTRUCTOR: For 240 bed hospital. 60 students. B.S. Degree and experience required. Maintenance available. Salary open. Apply Director of Nursing, Montgomery Hospital, Norristown, Pa.

EDUCATIONAL DIRECTOR: Unit of university group. New dormitory. All modern

cducational facilities. Student enrollment, 130. University city, South. $4200. RN9-7 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

EDUCATIONAL DIRECTOR: 500 bed eastern hospital. Masters' Degree required. $4000. (N174) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

EDUCATIONAL DIRECTOR: Chicago suburban hospital with 5 year collegiate program. $300. (N164) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

GENERAL DUTY NURSES: Two. Small general hospital operated by large industrial company. Small town, short distance from fashionable winter resort city of 200,000. $3408. Complete maintenance, with quarters in air-conditioned home, provided at $35 monthly. RN9-10 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSES: 45 bed general hospital in West Texas. Salary $220 per month with full maintenance. 48 hour week. Liberal personnel policies. Big Spring Hospital Corp., Big Spring, Tex.

GENERAL DUTY NURSES: For all services in 569 bed general and teaching hospital. 44 hour week. Cash salary $42-46 per week plus evening-night premiums. Free Blue Cross. 3 week vacation. 9 holidays, two week sick leave, all with pay. Excellent personnel policies. Apply Director of Nursing Service, Rhode Island Hospital, Providence 2, R.I.

GENERAL DUTY NURSES: Qualified to take responsibility in Surgery also. Starting salary Penna. Registration $2418.00 per year, less maintenance. Straight 8 hour shifts. Inquire Medical Director, Pennsylvania State T.B. Hospital, Cresson, Pa.

GENERAL DUTY NURSES: $180 with full maintenance and $5 raise each three months. Two weeks' vacation, six days' sick leave, six holidays. General hospital in Panhandle of Texas. Apply to Superintendent of Nurses, North Plains Hospital, Borger, Tex.

HEAD NURSES: Newly opened 500 bed preventive psychiatric institution located 15 miles south of Wilmington. Full maintenance available with all recreational facilities. Salary open, depending upon training and experience. Apply Director of Nurses, Govenor Bacon Health Center, Delaware City, Del.

MALE NURSE: Clinic serving employees of American company in foreign country. Substantial salary including maintenance transportation. RN9-A11 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

MALE NURSE: All male General Duty and Surgery. House for family and $300 per month. Contact S. W. Moore, M.D., Moore Clinic, Vandalia, Ill.

MALE NURSE: Large teaching hospital. Duties consist of operating room work with special reference to skin grafting and dressing of burns. University center, South. RN9-

11 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

NURSE ANESTHETIST: Fully approved. General Hospital. Assistant to Doctor Anesthetist. Pleasant working conditions. Salary open, maintenance available. Good Samaritan Hospital, Lebanan, Pa.

NURSES: General Duty, Head and Supervisory Nurses in acute communicable, TB or general emergency hospitals. Public Health Nurses and Public Health Nurses in Training. Salaries from $2876 to $4573. 40 hour week, no split shifts. Paid vacations, duty disability allowances, sick leaves, maternity leaves, pensions, death and sickness benefits. Apply Detroit Civil Service Commission. 735 Randolph Street, Detroit 26, Mich.

NURSES: Registered and Under Graduate Nurses for general duty, 50 bed private tuberculosis sanatorium, Southern California. Excellent living and working conditions. Apply La Vina Sanatorium, La Vina, Calif.

NURSES: Immediate openings in the Texas Medical Center for registered nurses interested in General Staff, Head Nurse and Supervisory positions. Maximum beginning salary for General Staff Nursing $220 per month. 44 hour working week and uniform laundry. Liberal paid vacation, holidays and sick leave. Salaries for Head Nurses and Supervisors open, being based on experience and post-graduate work or college credits in nursing. Apply to Director of Nursing Service, Hermann Hospital, Houston, Texas.

NURSING ARTS INSTRUCTOR: Vacancy Sept. 1. 130 bed hospital, 32 students. 40 hour week. Excellent personnel policies. Salary depends on preparation and experience. Apply Director of Nurses, Amsterdam Hospital, Amsterdam, N.Y.

NURSING ARTS INSTRUCTOR: General hospital, 175 beds. Town of 50,000, near university center. $300, maintenance. RN9-8 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

NURSES: Registered. $195 plus meals and uniform laundry. $5 for night, alternate shifts. 2 weeks' vacation and sick leave after one year. Straight 3-11 or 11-7 if desired. Hand Memorial Hospital, Shenandoah, Iowa.

NURSING ARTS INSTRUCTOR: College faculty appointment. 150 bed midwestern hospital. $300 minimum. (N262) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

OBSTETRICAL SUPERVISOR: Teaching hospital, university center. Opportunity for continuing studies. Middle West. $275-280, increasing. RN9-16 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

OBSTETRICAL SUPERVISOR: 130 bed general hospital, school of nursing. 40 students, 20 beds and bassinetts Obstetrical Division. Post graduate course and college credits, preferably B.S., desired. 40 hour week. Salary open. Write Director of Nurses, Amsterdam Hospital, Amsterdam, N.Y.

OFFICE NURSE: Graduate nurse to assist chief surgeon, large industrial company. Should be qualified in routine laboratory work, basal metabolism. East. RN9-13 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

OPERATING ROOM SUPERVISOR: Puerto Rico. 100 bed modern hospital adjacent to country club. (N277) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

OPERATING ROOM SUPERVISOR: Small, general hospital located in Rio Grande Valley, short distance from Mexican Border, semi-tropical climate. $285, complete maintenance. RN9-18 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

OUTPATIENT SUPERVISOR: Qualified to organize and develop generalized program. Expanding department. Fairly large hospital, university center, Middle West. RN9-17 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PEDIATRIC SUPERVISOR: General hospital of 500 beds. University city having two universities, several colleges. $225-$300. RN9-19 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PSYCHIATRIC SUPERVISORS: Two. Position open for day and night duty. Private approved 90 bed hospital near Cleveland. Salary with complete maintenance. 2 weeks' vacation, 7 holidays, sick leave. State salary

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PUBLIC HEALTH NURSE: Generalized program. Assistant to County Nurse. Mileage allowance. Desirable working conditions. Inquire: O. Damrow, Sheboygan County Health Committee, Court House, Sheboygan, Wis.

PUBLIC HEALTH NURSES: Supervisor of nurses and several staff nurses. Generalized program, expansion program. Salaries, respectively, $350-$400, $275-$310. California. RN9-14 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

PUBLIC HEALTH NURSE: Chicago Area. Full-time appointment. $3000 yearly. (N311) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

PUBLIC HEALTH NURSE: Salary open, mileage. Must have car. Qualified Public Health Nurses write Mrs. T. W. Scott, Box 66, Prairie City, Grant County, Ore.

RECORD LIBRARIAN: Immediate opening in 80 bed hospital for experienced person. Write Memorial Hospital of Sheridan County, Sheridan, Wyo.

REGISTERED NURSES: Several. General duty and supervising positions open. 40 bed private psychiatric hospital. Laundry and meals included. Beginning salary $200 per month. Psychiatric experience not necessary. Write full qualifications to Mrs. Ruth Sherman, McMillen Sanitarium, 840 N. Nelson Road, Columbus 3, Ohio.

REGISTERED NURSES: For staff duty. 65 bed modern hospital. Complete maintenance. 44 hour week, straight 8 hour duty. Vacation, sick leave, all holidays. Extra pay for 3-11 and 11-7 duty. Increases at six-month intervals. Apply Supt. Nurses, Winter Haven Hospital, Winter Haven, Fla.

REGISTERED NURSES: All services or shifts in 150 bed general hospital. Straight 8 hour, 44 hour week. Vacation and sick leave with pay. Beginning $8.00 per day, $8.60 per evening or night. Inexpensive rooms in vicinity. Apply Director of Nurses, Glenville Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

SCHOOL NURSE: Public schools, small town, Coast of California. Duties: directing school health program. RN9-15 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SCIENCE INSTRUCTOR: East. 100 bed general hospital. $300, maintenance. (N178) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

SCIENCE AND NURSING ARTS INSTRUCTORS: One of leading hospitals, Chicago area. 40 hour week. Salaries $3900. RN9-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SCIENCE INSTRUCTOR: Vacancy Sept. 1. 130 bed hospital, 32 students. 40 hour week. Excellent personnel policies. Salary depends on preparation and experience. Apply Director of Nurses, Amsterdam Hospital, Amsterdam, N.Y.

STAFF NURSE: 20 bed industrial hospital. Arizona. Air-condition·d living quarters. $285 per month. (N155) Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

STAFF NURSES: Starting salary $2640 a year including maintenance. 8 hour day. Yearly increases to $3200. Liberal vacation and sick leave, pension plan, pleasant living quarters. Maintenance charge $480 a year. Apply Supt. of Nurses, Essex County Sanatorium, Verona, N.J.

SURGICAL NURSE: Small hospital in Hawaii. Duties include charge of central supply and outpatient departments. Two full-time assistants. RN9-12 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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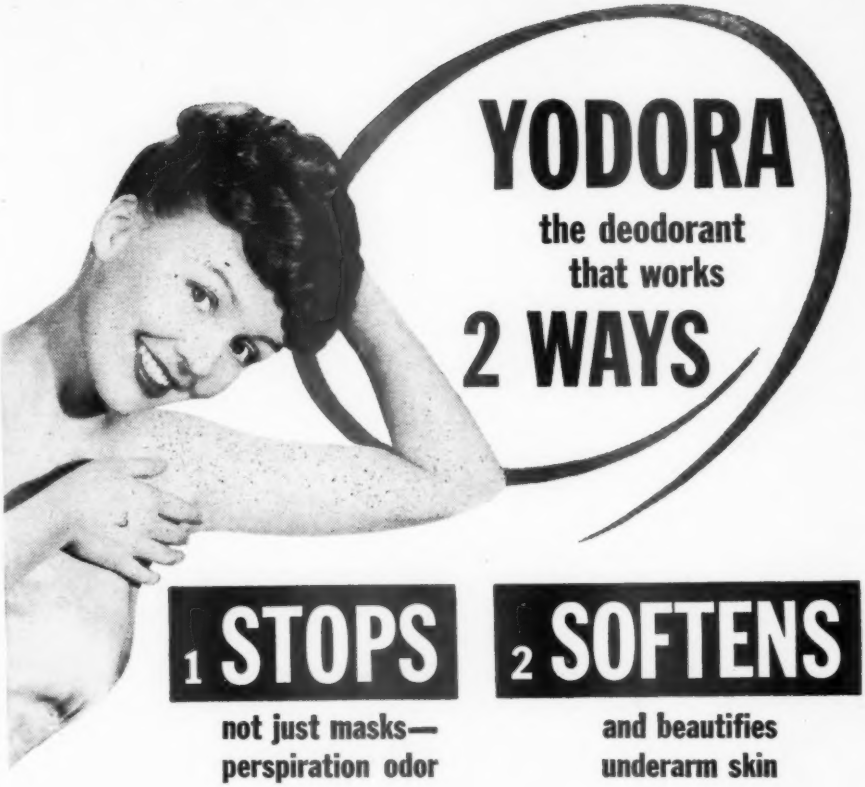

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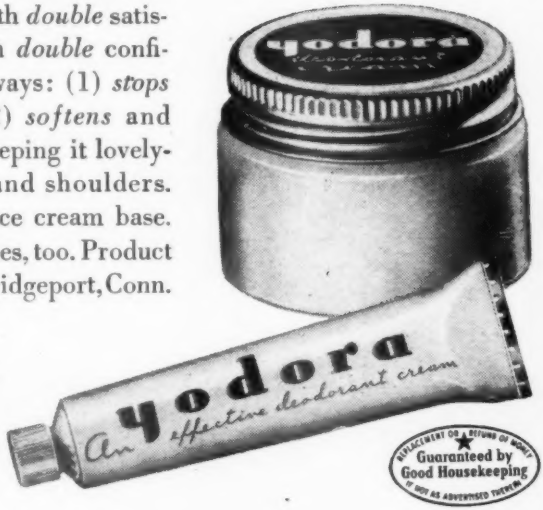

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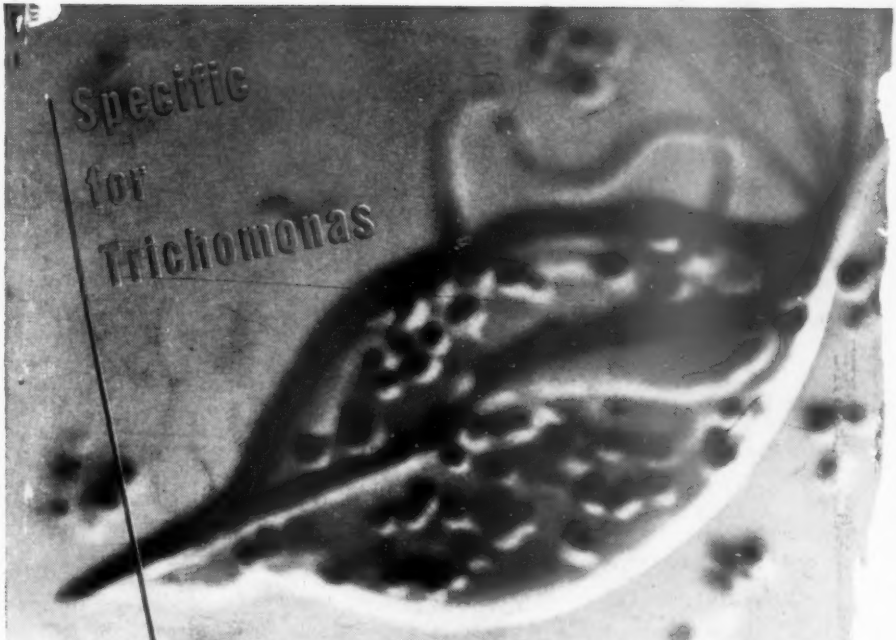

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